Axel & Associates, Inc.

MANAGEMENT CONSULTANTS

by FedEX

June19, 2017

Ms. Courtney Avery
Administrator
Illinois Health Facilities and
Services Review Board
525 West Jefferson
Springfield, IL 62761

Dear Courtney:

Enclosed please find two copies of a Certificate of Need application addressing the addition of an approved surgical specialty at Elmhurst Foot & Ankle Surgery Center. Also enclosed is a check, in the amount of $2,500.00, as a filing fee.

Should any additional information be required, please do not hesitate to contact me.

Sincerely,

Jacob M. Axel
President

enclosures

675 North Court, Suite 210
Palatine, Illinois 60067

Phone (847) 776-7101
Fax (847) 776-7004

17-026

ORIGINAL

ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD
APPLICATION FOR PERMIT

RECEIVED

JUN 21 2017

HEALTH FACILITIES & SERVICES REVIEW BOARD

SECTION I. IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION

This Section must be completed for all projects.

Facility/Project Identification

Facility Name:	Elmhurst Foot & Ankle Surgery Center			
Street Address:	340 West Butterfield Road			
City and Zip Code:	Elmhurst, IL 60126			
County:	DuPage	Health Service Area:	VII	Health Planning Area: n/a

Applicant(s) [Provide for each applicant (refer to Part 1130.220)]

Exact Legal Name:	River North Surgical Suites, Inc. d/b/a Elmhurst Foot & Ankle Surgery Center
Street Address:	c/o Mary Ellen Carr 467 W. Erie Street
City and Zip Code:	Chicago, IL 60654
Name of Registered Agent:	Mary Ellen Carr
Registered Agent Street Address:	647 W. Erie Street
Registered Agent City and Zip Code:	Chicago, IL 60654
Name of Chief Executive Office	
CEO Street Address:	
CEO City and Zip Code:	
CEO Telephone Number:	

ORIGINAL SIGNATURES IN THIS COPY

Type of Ownership of App

- ☐ Non-profit Corporation
- X For-profit Corporation
- ☐ Limited Liability Compa
- ☐ Other

- o Corporations and limite **tificate of good standing.**
- o Partnerships must prov ized and the name and address of each partne partner.

APPEND DOCUMENTATION AS ATTACHMENT 1 IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

Primary Contact [Person to receive ALL correspondence or inquiries]

Name:	Jacob M. Axel
Title:	President
Company Name:	Axel & Associates, Inc.
Address:	675 North Court, Suite 210 Palatine, IL 60067
Telephone Number:	847/776-7101
E-mail Address:	jacobmaxel@msn.com
Fax Number:	847/776-7004

Additional Contact [Person who is also authorized to discuss the application for permit]

Name:	none
Title:	
Company Name:	
Address:	
Telephone Number:	
E-mail Address:	
Fax Number:	

ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD
APPLICATION FOR PERMIT

SECTION I. IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION

This Section must be completed for all projects.

Facility/Project Identification

Facility Name:	Elmhurst Foot & Ankle Surgery Center
Street Address:	340 West Butterfield Road
City and Zip Code:	Elmhurst, IL 60126
County: DuPage	Health Service Area: VII Health Planning Area: n/a

Applicant(s) [Provide for each applicant (refer to Part 1130.220)]

Exact Legal Name:	TEC Surgical Properties, Inc.
Street Address:	c/o Mary Ellen Carr 467 W. Erie Street
City and Zip Code:	Chicago, IL 60654
Name of Registered Agent:	Mary Ellen Carr
Registered Agent Street Address:	647 W. Erie Street
Registered Agent City and Zip Code:	Chicago, IL 60654
Name of Chief Executive Officer:	Thomas Carr, DPM
CEO Street Address:	647 W. Erie Street
CEO City and Zip Code:	Chicago, IL 60654
CEO Telephone Number:	312/337-9900

Type of Ownership of Applicants

- ☐ Non-profit Corporation
- X For-profit Corporation
- ☐ Limited Liability Company
- ☐ Partnership
- ☐ Governmental
- ☐ Sole Proprietorship
- ☐ Other

- o Corporations and limited liability companies must provide an **Illinois certificate of good standing.**
- o Partnerships must provide the name of the state in which they are organized and the name and address of each partner specifying whether each is a general or limited partner.

APPEND DOCUMENTATION AS ATTACHMENT 1 IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

Primary Contact [Person to receive ALL correspondence or inquiries]

Name:	Jacob M. Axel
Title:	President
Company Name:	Axel & Associates, Inc.
Address:	675 North Court, Suite 210 Palatine, IL 60067
Telephone Number:	847/776-7101
E-mail Address:	jacobmaxel@msn.com
Fax Number:	847/776-7004

Additional Contact [Person who is also authorized to discuss the application for permit]

Name:	none
Title:	
Company Name:	
Address:	
Telephone Number:	
E-mail Address:	
Fax Number:	

Post Permit Contact

[Person to receive all correspondence subsequent to permit issuance-**THIS PERSON MUST BE EMPLOYED BY THE LICENSED HEALTH CARE FACILITY AS DEFINED AT 20 ILCS 3960**]

Name:	Thomas Carr, DPM
Title:	President
Company Name:	River North Surgical Suites, Inc.
Address:	467 W. Erie Street Chicago, IL 60654
Telephone Number:	312/337-9900
E-mail Address:	dr.tcarr@gmail.com
Fax Number:	

Site Ownership

[Provide this information for each applicable site]

Exact Legal Name of Site Owner: TEC Surgical Properties, LLC

Address of Site Site Owner: 467 W. Erie Street Chicago, IL 60654

Street Address or Legal Description of the Site: 340 W. Butterfield Road Elmhurst, IL 60126

Proof of ownership or control of the site is to be provided as Attachment 2. Examples of proof of ownership are property tax statements, tax assessor's documentation, deed, notarized statement of the corporation attesting to ownership, an option to lease, a letter of intent to lease, or a lease.

APPEND DOCUMENTATION AS ATTACHMENT 2, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

Operating Identity/Licensee

[Provide this information for each applicable facility and insert after this page.]

Exact Legal Name: River North Surgical Suites, Inc. d/b/a Elmhurst Foot & Ankle Surgery Center

Address: 467 W. Erie Street Chicago, IL 60654

- ☐ Non-profit Corporation
- X For-profit Corporation
- ☐ Limited Liability Company
- ☐ Partnership
- ☐ Governmental
- ☐ Sole Proprietorship
- ☐ Other

- Corporations and limited liability companies must provide an Illinois Certificate of Good Standing.
- Partnerships must provide the name of the state in which organized and the name and address of each partner specifying whether each is a general or limited partner.
- **Persons with 5 percent or greater interest in the licensee must be identified with the % of ownership.**

APPEND DOCUMENTATION AS ATTACHMENT 3, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

Organizational Relationships

Provide (for each applicant) an organizational chart containing the name and relationship of any person or entity who is related (as defined in Part 1130.140). If the related person or entity is participating in the development or funding of the project, describe the interest and the amount and type of any financial contribution.

APPEND DOCUMENTATION AS ATTACHMENT 4, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

Flood Plain Requirements

not applicable

[Refer to application instructions.]

Provide documentation that the project complies with the requirements of Illinois Executive Order #2006-5 pertaining to construction activities in special flood hazard areas. As part of the flood plain requirements, please provide a map of the proposed project location showing any identified floodplain areas. Floodplain maps can be printed at **www.FEMA.gov** or **www.illinoisfloodmaps.org**. **This map must be in a readable format**. In addition, please provide a statement attesting that the project complies with the requirements of Illinois Executive Order #2006-5 **(http://www.hfsrb.illinois.gov)**.

APPEND DOCUMENTATION AS ATTACHMENT 5, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

Historic Resources Preservation Act Requirements

not applicable

[Refer to application instructions.]

Provide documentation regarding compliance with the requirements of the Historic Resources Preservation Act.

APPEND DOCUMENTATION AS ATTACHMENT 6, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

DESCRIPTION OF PROJECT

1. Project Classification

[Check those applicable - refer to Part 1110.40 and Part 1120.20(b)]

Part 1110 Classification:

☐ Substantive

X Non-substantive

2. Narrative Description

In the space below, provide a brief narrative description of the project. Explain **WHAT** is to be done in **State Board defined terms**, **NOT WHY** it is being done. If the project site does NOT have a street address, include a legal description of the site. Include the rationale regarding the project's classification as substantive or non-substantive.

The project is limited to the addition of a surgical specialty (orthopedic surgery) to a limited specialty ambulatory surgical treatment center ("ASTC") currently approved to provide only podiatric surgery services.

The project involves no construction, renovation, significant acquisition of equipment, or any other capitalized costs.

The ASTC is located at 340 W. Butterfield Road in Elmhurst, Illinois.

The proposed project does not meet the definition of a "substantive" project, and is therefore classified as "non-substantive".

Project Costs and Sources of Funds

Complete the following table listing all costs (refer to Part 1120.110) associated with the project. When a project or any component of a project is to be accomplished by lease, donation, gift, or other means, the fair market or dollar value (refer to Part 1130.140) of the component must be included in the estimated project cost. If the project contains non-reviewable components that are not related to the provision of health care, complete the second column of the table below. Note, the use and sources of funds must be equal.

Project Costs and Sources of Funds			
USE OF FUNDS	**CLINICAL**	**NONCLINICAL**	**TOTAL**
Preplanning Costs			
Site Survey and Soil Investigation			
Site Preparation			
Off Site Work			
New Construction Contracts			
Modernization Contracts			
Contingencies			
Architectural/Engineering Fees			
Consulting and Other Fees			
Movable or Other Equipment (not in construction contracts)			
Bond Issuance Expense (project related)			
Net Interest Expense During Construction (project related)			
Fair Market Value of Leased Space or Equipment			
Other Costs To Be Capitalized			
Acquisition of Building or Other Property (excluding land)			
TOTAL USES OF FUNDS	**$0**	**$0**	**$0**
SOURCE OF FUNDS	**CLINICAL**	**NONCLINICAL**	**TOTAL**
Cash and Securities			
Pledges			
Gifts and Bequests			
Bond Issues (project related)			
Mortgages			
Leases (fair market value)			
Governmental Appropriations			
Grants			
Other Funds and Sources			
TOTAL SOURCES OF FUNDS	**$0**	**$0**	**$0**

NOTE: ITEMIZATION OF EACH LINE ITEM MUST BE PROVIDED AT ATTACHMENT 7, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

Related Project Costs

Provide the following information, as applicable, with respect to any land related to the project that will be or has been acquired during the last two calendar years:

Land acquisition is related to project ☐ Yes X No

Purchase Price: $_____

Fair Market Value: $_____

The project involves the establishment of a new facility or a new category of service

☐ Yes X No

If yes, provide the dollar amount of all **non-capitalized** operating start-up costs (including operating deficits) through the first full fiscal year when the project achieves or exceeds the target utilization specified in Part 1100.

Estimated start-up costs and operating deficit cost is $ _____.

Project Status and Completion Schedules

For facilities in which prior permits have been issued please provide the permit numbers.

Indicate the stage of the project's architectural drawings:

X None or not applicable ☐ Preliminary

☐ Schematics ☐ Final Working

Anticipated project completion date (refer to Part 1130.140): _60 days post permit issuance___

Indicate the following with respect to project expenditures or to financial commitments (refer to Part 1130.140):

not applicable

☐ Purchase orders, leases or contracts pertaining to the project have been executed.

☐ Financial commitment is contingent upon permit issuance. Provide a copy of the contingent "certification of financial commitment" document, highlighting any language related to CON Contingencies

☐ Financial Commitment will occur after permit issuance.

APPEND DOCUMENTATION AS ATTACHMENT 8, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

State Agency Submittals [Section 1130.620(c)]

Are the following submittals up to date as applicable:

☐ Cancer Registry **not applicable**

☐ APORS **not applicable**

X All formal document requests such as IDPH Questionnaires and Annual Bed Reports been submitted

☐ All reports regarding outstanding permits **not applicable**

Failure to be up to date with these requirements will result in the application for permit being deemed incomplete.

Cost Space Requirements

not applicable

Provide in the following format, the **Departmental Gross Square Feet (DGSF)** or the **Building Gross Square Feet (BGSF)** and cost. The type of gross square footage either **DGSF** or **BGSF** must be identified. The sum of the department costs **MUST** equal the total estimated project costs. Indicate if any space is being reallocated for a different purpose. Include outside wall measurements plus the department's or area's portion of the surrounding circulation space. **Explain the use of any vacated space.**

		Gross Square Feet		Amount of Proposed Total Gross Square Feet That Is:			
Dept. / Area	**Cost**	**Existing**	**Proposed**	**New Const.**	**Modernized**	**As Is**	**Vacated Space**
REVIEWABLE							
Medical Surgical							
Intensive Care							
Diagnostic Radiology							
MRI							
Total Clinical							
NON REVIEWABLE							
Administrative							
Parking							
Gift Shop							
Total Non-clinical							
TOTAL							

APPEND DOCUMENTATION AS ATTACHMENT 9, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

Facility Bed Capacity and Utilization

not applicable

Complete the following chart, as applicable. Complete a separate chart for each facility that is a part of the project and insert the chart after this page. Provide the existing bed capacity and utilization data for the latest **Calendar Year for which data is available. Include observation days in the patient day totals for each bed service.** Any bed capacity discrepancy from the Inventory will result in the application being deemed **incomplete**.

FACILITY NAME:		**CITY:**			
REPORTING PERIOD DATES:		**From:**		**to:**	
Category of Service	**Authorized Beds**	**Admissions**	**Patient Days**	**Bed Changes**	**Proposed Beds**
Medical/Surgical					
Obstetrics					
Pediatrics					
Intensive Care					
Comprehensive Physical Rehabilitation					
Acute/Chronic Mental Illness					
Neonatal Intensive Care					
General Long Term Care					
Specialized Long Term Care					
Long Term Acute Care					
Other ((identify)					
TOTALS:					

CERTIFICATION

The Application must be signed by the authorized representatives of the applicant entity. Authorized representatives are:

- in the case of a corporation, any two of its officers or members of its Board of Directors;
- in the case of a limited liability company, any two of its managers or members (or the sole manager or member when two or more managers or members do not exist);
- in the case of a partnership, two of its general partners (or the sole general partner, when two or more general partners do not exist);
- in the case of estates and trusts, two of its beneficiaries (or the sole beneficiary when two or more beneficiaries do not exist); and
- in the case of a sole proprietor, the individual that is the proprietor.

This Application is filed on the behalf of _River North Surgical Suites, Inc. d/b/a Elmhurst Foot & Ankle Surgery Center_* in accordance with the requirements and procedures of the Illinois Health Facilities Planning Act. The undersigned certifies that he or she has the authority to execute and file this Application on behalf of the applicant entity. The undersigned further certifies that the data and information provided herein, and appended hereto, are complete and correct to the best of his or her knowledge and belief. The undersigned also certifies that the fee required for this application is sent herewith or will be paid upon request.

SIGNATURE

THOMAS CARR DPM
PRINTED NAME

CHAIR GOVERNING BOARD
PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 10 day of JUNE, 2017

Mary R. Plocinski
Signature of Notary

Seal

OFFICIAL SEAL
MARY R PLOCINSKI
Notary Public - State of Illinois
My Commission Expires Feb 26, 2018

* Insert the exact legal name of the applicant

SIGNATURE

PRINTED NAME

PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this _____ day of _____

Signature of Notary

Seal

CERTIFICATION

The Application must be signed by the authorized representatives of the applicant entity. Authorized representatives are:

- in the case of a corporation, any two of its officers or members of its Board of Directors;
- in the case of a limited liability company, any two of its managers or members (or the sole manager or member when two or more managers or members do not exist);
- in the case of a partnership, two of its general partners (or the sole general partner, when two or more general partners do not exist);
- in the case of estates and trusts, two of its beneficiaries (or the sole beneficiary when two or more beneficiaries do not exist); and
- in the case of a sole proprietor, the individual that is the proprietor.

This Application is filed on the behalf of __TEC Surgical Properties, LLc___* in accordance with the requirements and procedures of the Illinois Health Facilities Planning Act. The undersigned certifies that he or she has the authority to execute and file this Application on behalf of the applicant entity. The undersigned further certifies that the data and information provided herein, and appended hereto, are complete and correct to the best of his or her knowledge and belief. The undersigned also certifies that the fee required for this application is sent herewith or will be paid upon request.

SIGNATURE

Thomas Carr DPM
PRINTED NAME

Owner / Manager
PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 10 day of June, 2017

Mary R. Plocinski
Signature of Notary

Seal

OFFICIAL SEAL
MARY R PLOCINSKI
Notary Public - State of Illinois
My Commission Expires Feb 28, 2018

SIGNATURE

PRINTED NAME

PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this _____ day of _____

Signature of Notary

Seal

*Insert the EXACT legal name of the applicant

SECTION III. BACKGROUND, PURPOSE OF THE PROJECT, AND ALTERNATIVES - INFORMATION REQUIREMENTS

This Section is applicable to all projects except those that are solely for discontinuation with no project costs.

Background

READ THE REVIEW CRITERION and provide the following required information:

BACKGROUND OF APPLICANT

1. A listing of all health care facilities owned or operated by the applicant, including licensing, and certification if applicable.

2. A certified listing of any adverse action taken against any facility owned and/or operated by the applicant during the three years prior to the filing of the application.

3. Authorization permitting HFSRB and DPH access to any documents necessary to verify the information submitted, including, but not limited to official records of DPH or other State agencies; the licensing or certification records of other states, when applicable; and the records of nationally recognized accreditation organizations. **Failure to provide such authorization shall constitute an abandonment or withdrawal of the application without any further action by HFSRB.**

4. If, during a given calendar year, an applicant submits more than one application for permit, the documentation provided with the prior applications may be utilized to fulfill the information requirements of this criterion. In such instances, the applicant shall attest that the information was previously provided, cite the project number of the prior application, and certify that no changes have occurred regarding the information that has been previously provided. The applicant is able to submit amendments to previously submitted information, as needed, to update and/or clarify data.

APPEND DOCUMENTATION AS ATTACHMENT 11, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM. EACH ITEM (1-4) MUST BE IDENTIFIED IN ATTACHMENT 11.

Criterion 1110.230 – Purpose of the Project, and Alternatives

PURPOSE OF PROJECT

1. Document that the project will provide health services that improve the health care or well-being of the market area population to be served.

2. Define the planning area or market area, or other relevant area, per the applicant's definition.

3. Identify the existing problems or issues that need to be addressed as applicable and appropriate for the project.

4. Cite the sources of the documentation.

5. Detail how the project will address or improve the previously referenced issues, as well as the population's health status and well-being.

6. Provide goals with quantified and measurable objectives, with specific timeframes that relate to achieving the stated goals as appropriate.

For projects involving modernization, describe the conditions being upgraded, if any. For facility projects, include statements of the age and condition of the project site, as well as regulatory citations, if any. For equipment being replaced, include repair and maintenance records.

NOTE: Information regarding the "Purpose of the Project" will be included in the State Board Staff Report.

APPEND DOCUMENTATION AS ATTACHMENT 12, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM. EACH ITEM (1-6) MUST BE IDENTIFIED IN ATTACHMENT 12.

ALTERNATIVES

1) Identify **ALL** of the alternatives to the proposed project:

Alternative options **must** include:

A) Proposing a project of greater or lesser scope and cost;

B) Pursuing a joint venture or similar arrangement with one or more providers or entities to meet all or a portion of the project's intended purposes; developing alternative settings to meet all or a portion of the project's intended purposes;

C) Utilizing other health care resources that are available to serve all or a portion of the population proposed to be served by the project; and

D) Provide the reasons why the chosen alternative was selected.

2) Documentation shall consist of a comparison of the project to alternative options. The comparison shall address issues of total costs, patient access, quality and financial benefits in both the short-term (within one to three years after project completion) and long-term. This may vary by project or situation. **FOR EVERY ALTERNATIVE IDENTIFIED, THE TOTAL PROJECT COST AND THE REASONS WHY THE ALTERNATIVE WAS REJECTED MUST BE PROVIDED.**

3) The applicant shall provide empirical evidence, including quantified outcome data that verifies improved quality of care, as available.

APPEND DOCUMENTATION AS ATTACHMENT 13, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

SECTION IV. PROJECT SCOPE, UTILIZATION, AND UNFINISHED/SHELL SPACE

Criterion 1110.234 - Project Scope, Utilization, and Unfinished/Shell Space

READ THE REVIEW CRITERION and provide the following information:

SIZE OF PROJECT:

1. Document that the amount of physical space proposed for the proposed project is necessary and not excessive. **This must be a narrative and it shall include the basis used for determining the space and the methodology applied.**

2. If the gross square footage exceeds the BGSF/DGSF standards in Appendix B, justify the discrepancy by documenting one of the following:

    a. Additional space is needed due to the scope of services provided, justified by clinical or operational needs, as supported by published data or studies and certified by the facility's Medical Director.

    b. The existing facility's physical configuration has constraints or impediments and requires an architectural design that delineates the constraints or impediments.

    c. The project involves the conversion of existing space that results in excess square footage.

    d. Additional space is mandated by governmental or certification agency requirements that were not in existence when Appendix B standards were adopted.

Provide a narrative for any discrepancies from the State Standard. A table must be provided in the following format with Attachment 14.

SIZE OF PROJECT				
DEPARTMENT/SERVICE	PROPOSED BGSF/DGSF	STATE STANDARD	DIFFERENCE	MET STANDARD?

APPEND DOCUMENTATION AS ATTACHMENT 14, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

PROJECT SERVICES UTILIZATION:

This criterion is applicable only to projects or portions of projects that involve services, functions or equipment for which HFSRB has established utilization standards or occupancy targets in 77 Ill. Adm. Code 1100.

Document that in the second year of operation, the annual utilization of the service or equipment shall meet or exceed the utilization standards specified in 1110.Appendix B. **A narrative of the rationale that supports the projections must be provided.**

A table must be provided in the following format with Attachment 15.

UTILIZATION					
	DEPT./ SERVICE	HISTORICAL UTILIZATION (PATIENT DAYS) (TREATMENTS) ETC.	PROJECTED UTILIZATION	STATE STANDARD	MEET STANDARD?
YEAR 1					
YEAR 2					

APPEND DOCUMENTATION AS ATTACHMENT 15, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

UNFINISHED OR SHELL SPACE:

not applicable, project does not involve shell space

Provide the following information:

1. Total gross square footage (GSF) of the proposed shell space.

2. The anticipated use of the shell space, specifying the proposed GSF to be allocated to each department, area or function.

3. Evidence that the shell space is being constructed due to:
   a. Requirements of governmental or certification agencies; or
   b. Experienced increases in the historical occupancy or utilization of those areas proposed to occupy the shell space.

4. Provide:
   a. Historical utilization for the area for the latest five-year period for which data is available; and
   b. Based upon the average annual percentage increase for that period, projections of future utilization of the area through the anticipated date when the shell space will be placed into operation.

APPEND DOCUMENTATION AS ATTACHMENT 16, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

ASSURANCES:

not applicable, project does not involve shell space

Submit the following:

1. Verification that the applicant will submit to HFSRB a CON application to develop and utilize the shell space, regardless of the capital thresholds in effect at the time or the categories of service involved.

2. The estimated date by which the subsequent CON application (to develop and utilize the subject shell space) will be submitted; and

3. The anticipated date when the shell space will be completed and placed into operation.

APPEND DOCUMENTATION AS ATTACHMENT 17, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

G. Non-Hospital Based Ambulatory Surgery

Applicants proposing to establish, expand and/or modernize the Non-Hospital Based Ambulatory Surgery category of service must submit the following information.

ASTC Service
☐ Cardiovascular
☐ Colon and Rectal Surgery
☐ Dermatology
☐ General Dentistry
☐ General Surgery
☐ Gastroenterology
☐ Neurological Surgery
☐ Nuclear Medicine
☐ Obstetrics/Gynecology
☐ Ophthalmology
☐ Oral/Maxillofacial Surgery
X Orthopedic Surgery
☐ Otolaryngology
☐ Pain Management
☐ Physical Medicine and Rehabilitation
☐ Plastic Surgery
X Podiatric Surgery
☐ Radiology
☐ Thoracic Surgery
☐ Urology
☐ Other_____

3. READ the applicable review criteria outlined below and **submit the required documentation for the criteria:**

APPLICABLE REVIEW CRITERIA	Establish New ASTC or Service	Expand Existing Service
1110.1540(c)(2) – Service to GSA Residents	X	X
1110.1540(d) – Service Demand – Establishment of an ASTC or Additional ASTC Service	X	
1110.1540(e) – Service Demand – Expansion of Existing ASTC Service		X
1110.1540(f) – Treatment Room Need Assessment	X	X
1110.1540(g) – Service Accessibility	X	
1110.1540(h)(1) – Unnecessary Duplication/Maldistribution	X	
1110.1540(h)(2) – Maldistribution	X	
1110.1540(h)(3) – Impact to Area Providers	X	
1110.1540(i) – Staffing	X	X

1110.1540(j) – Charge Commitment	X	X
1110.1540(k) – Assurances	X	X

APPEND DOCUMENTATION AS <u>ATTACHMENT 25,</u> IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

M. Criterion 1110.3030 - Clinical Service Areas Other than Categories of Service

1. Applicants proposing to establish, expand and/or modernize Clinical Service Areas Other than categories of service must submit the following information:

2. Indicate changes by Service: Indicate # of key room changes by action(s):

Service	# Existing Key Rooms	# Proposed Key Rooms
☐ **Postsurgical Recovery-Stage 1**	1	1
☐ **Postsurgical Recovery-Stage 2**	2	2
☐		

3. READ the applicable review criteria outlined below and **submit the required documentation for the criteria:**

Project Type	Required Review Criteria
New Services or Facility or Equipment	(c) – Need Determination – Establishment
Service Modernization	(d)(1) – Deteriorated Facilities
	AND/OR
	(d)(2) – Necessary Expansion
	PLUS
	(d)(3)(A) – Utilization – Major Medical Equipment
	OR
	(d)(3)(B) – Utilization – Service or Facility

APPEND DOCUMENTATION AS ATTACHMENT 31, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

The following Sections DO NOT need to be addressed by the applicants or co-applicants responsible for funding or guaranteeing the funding of the project if the applicant has a bond rating of A- or better from Fitch's or Standard and Poor's rating agencies, or A3 or better from Moody's (the rating shall be affirmed within the latest 18-month period prior to the submittal of the application):

- **Section 1120.120 Availability of Funds – Review Criteria**
- **Section 1120.130 Financial Viability – Review Criteria**
- **Section 1120.140 Economic Feasibility – Review Criteria, subsection (a)**

VII. 1120.120 - AVAILABILITY OF FUNDS

The applicant shall document that financial resources shall be available and be equal to or exceed the estimated total project cost plus any related project costs by providing evidence of sufficient financial resources from the following sources, as applicable **[Indicate the dollar amount to be provided from the following sources]:**

_____ a) Cash and Securities – statements (e.g., audited financial statements, letters from financial institutions, board resolutions) as to:

1) the amount of cash and securities available for the project, including the identification of any security, its value and availability of such funds; and

2) interest to be earned on depreciation account funds or to be earned on any asset from the date of applicant's submission through project completion;

_____ b) Pledges – for anticipated pledges, a summary of the anticipated pledges showing anticipated receipts and discounted value, estimated time table of gross receipts and related fundraising expenses, and a discussion of past fundraising experience.

_____ c) Gifts and Bequests – verification of the dollar amount, identification of any conditions of use, and the estimated time table of receipts;

_____ d) Debt – a statement of the estimated terms and conditions (including the debt time period, variable or permanent interest rates over the debt time period, and the anticipated repayment schedule) for any interim and for the permanent financing proposed to fund the project, including:

1) For general obligation bonds, proof of passage of the required referendum or evidence that the governmental unit has the authority to issue the bonds and evidence of the dollar amount of the issue, including any discounting anticipated;

2) For revenue bonds, proof of the feasibility of securing the specified amount and interest rate;

3) For mortgages, a letter from the prospective lender attesting to the expectation of making the loan in the amount and time indicated, including the anticipated interest rate and any conditions associated with the mortgage, such as, but not limited to, adjustable interest rates, balloon payments, etc.;

4) For any lease, a copy of the lease, including all the terms and conditions, including any purchase options, any capital improvements to the property and provision of capital equipment;

5) For any option to lease, a copy of the option, including all terms and conditions.

_____ e) Governmental Appropriations – a copy of the appropriation Act or ordinance accompanied by a statement of funding availability from an official of the governmental unit. If funds are to be made available from subsequent fiscal years, a copy of a

	resolution or other action of the governmental unit attesting to this intent; f) Grants – a letter from the granting agency as to the availability of funds in terms of the amount and time of receipt; g) All Other Funds and Sources – verification of the amount and type of any other funds that will be used for the project.
N/A	**TOTAL FUNDS AVAILABLE**

APPEND DOCUMENTATION AS ATTACHMENT 34, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

SECTION VIII. 1120.130 - FINANCIAL VIABILITY

NOT APPLICABLE, PROJECT DOES NOT HAVE CAPITALIZED COSTS

All the applicants and co-applicants shall be identified, specifying their roles in the project funding or guaranteeing the funding (sole responsibility or shared) and percentage of participation in that funding.

Financial Viability Waiver

The applicant is not required to submit financial viability ratios if:

1. "A" Bond rating or better
2. All of the projects capital expenditures are completely funded through internal sources
3. The applicant's current debt financing or projected debt financing is insured or anticipated to be insured by MBIA (Municipal Bond Insurance Association Inc.) or equivalent
4. The applicant provides a third party surety bond or performance bond letter of credit from an A rated guarantor.

See Section 1120.130 Financial Waiver for information to be provided

APPEND DOCUMENTATION AS ATTACHMENT 35, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

The applicant or co-applicant that is responsible for funding or guaranteeing funding of the project shall provide viability ratios for the latest three years for which **audited financial statements are available and for the first full fiscal year at target utilization, but no more than two years following project completion.** When the applicant's facility does not have facility specific financial statements and the facility is a member of a health care system that has combined or consolidated financial statements, the system's viability ratios shall be provided. If the health care system includes one or more hospitals, the system's viability ratios shall be evaluated for conformance with the applicable hospital standards.

	Historical 3 Years			Projected
Enter Historical and/or Projected Years:				
Current Ratio				
Net Margin Percentage				
Percent Debt to Total Capitalization				
Projected Debt Service Coverage				
Days Cash on Hand				
Cushion Ratio				

Provide the methodology and worksheets utilized in determining the ratios detailing the calculation and applicable line item amounts from the financial statements. Complete a separate table for each co-applicant and provide worksheets for each.

Variance

Applicants not in compliance with any of the viability ratios shall document that another organization, public or private, shall assume the legal responsibility to meet the debt obligations should the applicant default.

APPEND DOCUMENTATION AS ATTACHMENT 36, IN NUMERICAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

SECTION IX. 1120.140 - ECONOMIC FEASIBILITY

NOT APPLICABLE, PROJECT DOES NOT HAVE CAPITALIZED COSTS

This section is applicable to all projects subject to Part 1120.

A. Reasonableness of Financing Arrangements

The applicant shall document the reasonableness of financing arrangements by submitting a notarized statement signed by an authorized representative that attests to one of the following:

1) That the total estimated project costs and related costs will be funded in total with cash and equivalents, including investment securities, unrestricted funds, received pledge receipts and funded depreciation; or

2) That the total estimated project costs and related costs will be funded in total or in part by borrowing because:

   A) A portion or all of the cash and equivalents must be retained in the balance sheet asset accounts in order to maintain a current ratio of at least 2.0 times for hospitals and 1.5 times for all other facilities; or

   B) Borrowing is less costly than the liquidation of existing investments, and the existing investments being retained may be converted to cash or used to retire debt within a 60-day period.

B. Conditions of Debt Financing

This criterion is applicable only to projects that involve debt financing. The applicant shall document that the conditions of debt financing are reasonable by submitting a notarized statement signed by an authorized representative that attests to the following, as applicable:

1) That the selected form of debt financing for the project will be at the lowest net cost available;

2) That the selected form of debt financing will not be at the lowest net cost available, but is more advantageous due to such terms as prepayment privileges, no required mortgage, access to additional indebtedness, term (years), financing costs and other factors;

3) That the project involves (in total or in part) the leasing of equipment or facilities and that the expenses incurred with leasing a facility or equipment are less costly than constructing a new facility or purchasing new equipment.

C. Reasonableness of Project and Related Costs

Read the criterion and provide the following:

1. Identify each department or area impacted by the proposed project and provide a cost and square footage allocation for new construction and/or modernization using the following format (insert after this page).

COST AND GROSS SQUARE FEET BY DEPARTMENT OR SERVICE									
Department (list below)	A	B	C	D	E	F	G	H	Total Cost (G + H)
	Cost/Square Foot New	Cost/Square Foot Mod.	Gross Sq. Ft. New	Gross Sq. Ft. Circ.*	Gross Sq. Ft. Mod.	Gross Sq. Ft. Circ.*	Const. $ (A x C)	Mod. $ (B x E)	
Contingency									
TOTALS									

* Include the percentage (%) of space for circulation

D. Projected Operating Costs

The applicant shall provide the projected direct annual operating costs (in current dollars per equivalent patient day or unit of service) for the first full fiscal year at target utilization but no more than two years following project completion. Direct cost means the fully allocated costs of salaries, benefits and supplies for the service.

E. Total Effect of the Project on Capital Costs

The applicant shall provide the total projected annual capital costs (in current dollars per equivalent patient day) for the first full fiscal year at target utilization but no more than two years following project completion.

APPEND DOCUMENTATION AS ATTACHMENT 37, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

SECTION X. SAFETY NET IMPACT STATEMENT

SAFETY NET IMPACT STATEMENT that describes all of the following must be submitted for ALL SUBSTANTIVE PROJECTS AND PROJECTS TO DISCONTINUE STATE-OWNED HEALTH CARE FACILITIES [20 ILCS 3960/5.4]:

1. The project's material impact, if any, on essential safety net services in the community, to the extent that it is feasible for an applicant to have such knowledge.

2. The project's impact on the ability of another provider or health care system to cross-subsidize safety net services, if reasonably known to the applicant.

3. How the discontinuation of a facility or service might impact the remaining safety net providers in a given community, if reasonably known by the applicant.

Safety Net Impact Statements shall also include all of the following:

1. For the 3 fiscal years prior to the application, a certification describing the amount of charity care provided by the applicant. The amount calculated by hospital applicants shall be in accordance with the reporting requirements for charity care reporting in the Illinois Community Benefits Act. Non-hospital applicants shall report charity care, at cost, in accordance with an appropriate methodology specified by the Board.

2. For the 3 fiscal years prior to the application, a certification of the amount of care provided to Medicaid patients. Hospital and non-hospital applicants shall provide Medicaid information in a manner consistent with the information reported each year to the Illinois Department of Public Health regarding "Inpatients and Outpatients Served by Payor Source" and "Inpatient and Outpatient Net Revenue by Payor Source" as required by the Board under Section 13 of this Act and published in the Annual Hospital Profile.

3. Any information the applicant believes is directly relevant to safety net services, including information regarding teaching, research, and any other service.

A table in the following format must be provided as part of Attachment 40.

Safety Net Information per PA 96-0031			
CHARITY CARE			
Charity (# of patients)		**2015**	**2016**
Inpatient			
Outpatient		0	0
Total			
Charity (cost in dollars)			
Inpatient			
Outpatient			
Total		**$0**	**$0**
MEDICAID			
Medicaid (# of patients)		**2015**	**2016**
Inpatient			
Outpatient		1	4
Total			
Medicaid (revenue)			
Inpatient			
Outpatient		$0	$2,786
Total		$0	$2,786

APPEND DOCUMENTATION AS ATTACHMENT 38, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

SECTION XI. CHARITY CARE INFORMATION

Charity Care information MUST be furnished for ALL projects [1120.20(c)].

1. All applicants and co-applicants shall indicate the amount of charity care for the latest three **audited** fiscal years, the cost of charity care and the ratio of that charity care cost to net patient revenue.

2. If the applicant owns or operates one or more facilities, the reporting shall be for each individual facility located in Illinois. If charity care costs are reported on a consolidated basis, the applicant shall provide documentation as to the cost of charity care; the ratio of that charity care to the net patient revenue for the consolidated financial statement; the allocation of charity care costs; and the ratio of charity care cost to net patient revenue for the facility under review.

3. If the applicant is not an existing facility, it shall submit the facility's projected patient mix by payer source, anticipated charity care expense and projected ratio of charity care to net patient revenue by the end of its second year of operation.

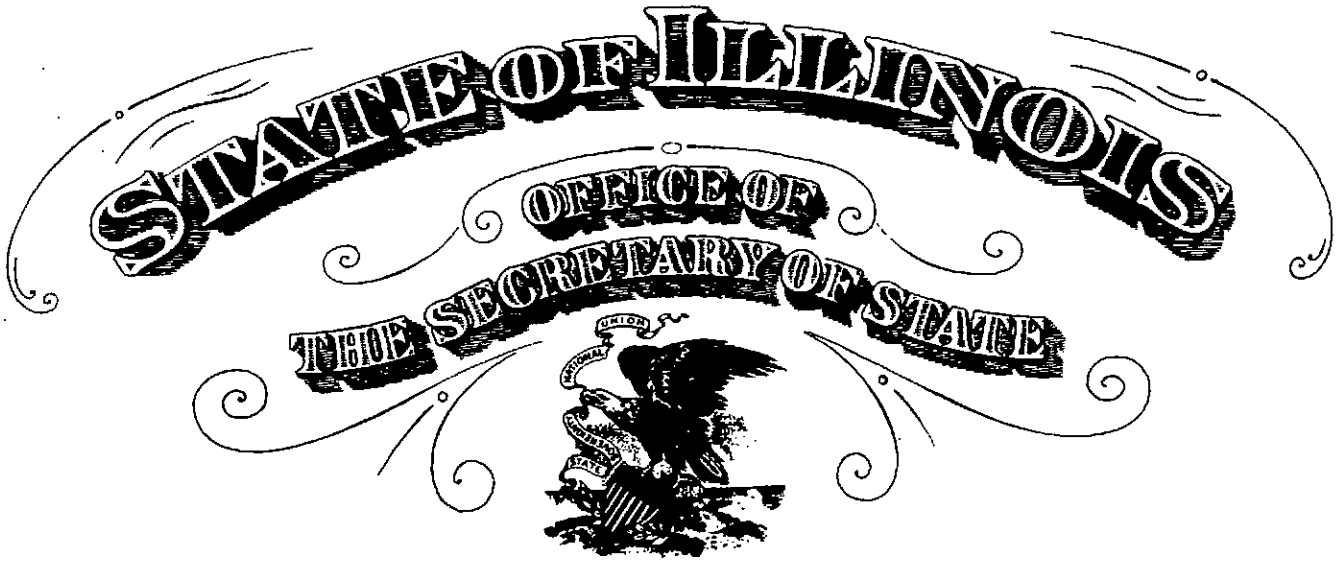
Charity care" means care provided by a health care facility for which the provider does not expect to receive payment from the patient or a third-party payer (20 ILCS 3960/3). Charity Care must be provided at cost.

A table in the following format must be provided for all facilities as part of Attachment 41.

CHARITY CARE			
		2015	**2016**
Net Patient Revenue		**$139,270**	**$351,745**
Amount of Charity Care (charges)			
Cost of Charity Care		$5,675	$0

APPEND DOCUMENTATION AS ATTACHMENT 39, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

File Number 6135-562-6



To all to whom these Presents Shall Come, Greeting:

I, Jesse White, Secretary of State of the State of Illinois, do hereby certify that I am the keeper of the records of the Department of Business Services. I certify that

RIVER NORTH SURGICAL SUITES INC., A DOMESTIC CORPORATION, INCORPORATED UNDER THE LAWS OF THIS STATE ON NOVEMBER 17, 2000, APPEARS TO HAVE COMPLIED WITH ALL THE PROVISIONS OF THE BUSINESS CORPORATION ACT OF THIS STATE RELATING TO THE PAYMENT OF FRANCHISE TAXES, AND AS OF THIS DATE, IS IN GOOD STANDING AS A DOMESTIC CORPORATION IN THE STATE OF ILLINOIS.

In Testimony Whereof, *I hereto set my hand and cause to be affixed the Great Seal of the State of Illinois, this* 16TH *day of* MAY *A.D.* 2017 .

Authentication #: 1713601544 verifiable until 05/16/2018
Authenticate at: http://www.cyberdriveillinois.com

Jesse White
SECRETARY OF STATE

ATTACHMENT 1

File Number 0482579-9

STATE OF ILLINOIS

OFFICE OF THE SECRETARY OF STATE

To all to whom these Presents Shall Come, Greeting:

I, Jesse White, Secretary of State of the State of Illinois, do hereby certify that I am the keeper of the records of the Department of Business Services. I certify that

TEC SURGICAL PROPERTIES LLC, HAVING ORGANIZED IN THE STATE OF ILLINOIS ON APRIL 30, 2014, APPEARS TO HAVE COMPLIED WITH ALL PROVISIONS OF THE LIMITED LIABILITY COMPANY ACT OF THIS STATE, AND AS OF THIS DATE IS IN GOOD STANDING AS A DOMESTIC LIMITED LIABILITY COMPANY IN THE STATE OF ILLINOIS.

In Testimony Whereof, *I hereto set my hand and cause to be affixed the Great Seal of the State of Illinois, this* 16TH *day of* MAY *A.D.* 2017 .

Jesse White

SECRETARY OF STATE

Authentication #: 1713601648 verifiable until 05/16/2018

Authenticate at: http://www.cyberdriveillinois.com

ATTACHMENT 1

Illinois Health Facilities and
Services Review Board
Springfield, Illinois

To Whom It May Concern:

I hereby attest that TEC Surgical Properties, Inc. maintains control of the site of Elmhurst Foot & Ankle Surgery Center, which is located on the first floor at 340 West Butterfield Road in Elmhurst Illinois.

Sincerely,

Thomas Carr, DPM

Date: 6-10, 2017

Notarized: Mary R. Plocinski

OFFICIAL SEAL
MARY R PLOCINSKI
Notary Public - State of Illinois
My Commission Expires Feb.26, 2018

ATTACHMENT 2

OPERATING IDENTITY/LICENSEE

Thomas Carr, DPM owns a 100% interest in River North Surgical Suites, Inc.

ATTACHMENT 3

File Number 6135-562-6

STATE OF ILLINOIS

OFFICE OF THE SECRETARY OF STATE

To all to whom these Presents Shall Come, Greeting:

I, Jesse White, Secretary of State of the State of Illinois, do hereby certify that I am the keeper of the records of the Department of Business Services. I certify that

RIVER NORTH SURGICAL SUITES INC., A DOMESTIC CORPORATION, INCORPORATED UNDER THE LAWS OF THIS STATE ON NOVEMBER 17, 2000, APPEARS TO HAVE COMPLIED WITH ALL THE PROVISIONS OF THE BUSINESS CORPORATION ACT OF THIS STATE RELATING TO THE PAYMENT OF FRANCHISE TAXES, AND AS OF THIS DATE, IS IN GOOD STANDING AS A DOMESTIC CORPORATION IN THE STATE OF ILLINOIS.

In Testimony Whereof, *I hereto set my hand and cause to be affixed the Great Seal of the State of Illinois, this* 16TH *day of* MAY *A.D.* 2017 .

Jesse White

SECRETARY OF STATE

Authentication #: 1713601544 verifiable until 05/16/2018

Authenticate at: http://www.cyberdriveillinois.com

ATTACHMENT 3

ORGANIZATION

River North Surgical Suites, Inc. d/b/a Elmhurst Foot & Ankle Surgery Center is fully owned by Thomas Carr, DPM.

ATTACHMENT 4

Illinois Department of PUBLIC HEALTH

HF112212

LICENSE, PERMIT, CERTIFICATION, REGISTRATION

The person, firm or corporation whose name appears on this certificate has complied with the provisions of the Illinois statutes and/or rules and regulations and is hereby authorized to engage in the activity as indicated below.

Nirav D. Shah, M.D., J.D.
Director

Issued under the authority of the Illinois Department of Public Health

EXPIRATION DATE	CATEGORY	I.D. NUMBER
12/13/2017		7003192

Ambulatory Surgery Treatment Center

Effective: 12/14/2016

River North Surgical Suites Inc
dba Elmhurst Foot & Ankle Surgery Center Inc
340 West Butterfield Road Suite 1B

Elmhurst, IL 60126

The face of this license has a colored background. Printed by Authority of the State of Illinois • P.O. #4012320 10M 3/12

DISPLAY THIS PART IN A CONSPICUOUS PLACE

Exp. Date 12/13/2017

Lic Number 7003192

Date Printed 11/30/2016

River North Surgical Suites Inc
dba Elmhurst Foot & Ankle Surgery Ce
340 West Butterfield Road Suite 1B
Elmhurst, IL 60126

FEE RECEIPT NO.

The Joint Commission

June 19, 2015

Thomas Carr, DPM
President
River North Surgical Suites Inc
340 W Butterfield Road, Suite 1B
Elmhurst, IL 60126

Joint Commission ID #: 513113
Program: Ambulatory Health Care Accreditation
Accreditation Activity: 60-day Evidence of Standards Compliance
Accreditation Activity Completed: 06/19/2015

Dear Dr. Carr:

The Joint Commission would like to thank your organization for participating in the accreditation process. This process is designed to help your organization continuously provide safe, high-quality care, treatment, and services by identifying opportunities for improvement in your processes and helping you follow through on and implement these improvements. We encourage you to use the accreditation process as a continuous standards compliance and operational improvement tool.

The Joint Commission is granting your organization an accreditation decision of Accredited for all services surveyed under the applicable manual(s) noted below:

- Comprehensive Accreditation Manual for Ambulatory Health Care

This accreditation cycle is effective beginning May 02, 2015. The Joint Commission reserves the right to shorten or lengthen the duration of the cycle; however, the certificate and cycle are customarily valid for up to 36 months.

Please visit Quality Check® on The Joint Commission web site for updated information related to your accreditation decision.

We encourage you to share this accreditation decision with your organization's appropriate staff, leadership, and governing body. You may also want to inform the state or regional regulatory services, and the public you serve of your organization's accreditation decision.

Please be assured that The Joint Commission will keep the report confidential, except as required by law. To ensure that The Joint Commission's information about your organization is always accurate and current, our policy requires that you inform us of any changes in the name or ownership of your organization or the health care services you provide.

Sincerely,

Mark Pelletier

Mark G.Pelletier, RN, MS

Chief Operating Officer

Division of Accreditation and Certification Operations

ATTACHMENT 11

Ms. Courtney Avery
Illinois Health Facilities
And Services review Board
525 West Jefferson
Springfield, IL 62761

Dear Ms. Avery:

In accordance with Review Criterion 1110.230.b, Background of the Applicant, we are submitting this letter assuring the Illinois Health Facilities and Services Review Board that:

1. River North Surgical Suites, Inc. d/b/a Elmhurst Foot & Ankle Surgery Center and TEC Surgical Properties, Inc. hereafter jointly referred to as "the applicants", have not had any adverse actions against any facility owned and operated by the applicants during the three (3) year period prior to the filing of this application, and
2. The applicants authorize the State Board and Agency access to information to verify documentation or information submitted in response to the requirements of Review Criterion 1110.230.b or to obtain any documentation or information which the State Board or Agency finds pertinent to this application.

If we can in any way provide assistance to your staff regarding these assurances or any other issue relative to this application, please do not hesitate to call me.

Sincerely,

Thomas Carr, DPM

Date: 6-10-, 2017

Notarized: Mary R. Plocinski

OFFICIAL SEAL
MARY R PLOCINSKI
Notary Public - State of Illinois
My Commission Expires Feb.26, 2018

ATTACHMENT 11

PURPOSE OF PROJECT

The proposed project will improve the health and well-being of the market area's population by bringing outpatient orthopedic surgery services not previously accessible at Elmhurst Foot & Ankle Surgery Center to the ASTC. This improvement will result from the issuance of the requested CON Permit, allowing the addition of the service at the ASTC, and the addition of an orthopedic surgeon, Dr. Daryl O'Connor to the ASTC's medical staff.

The service area for ASTC's, per the definition in Section 1110, extends 45 minutes in all directions from the ASTC. Based on the ASTC's historical patient origin, as well as that of Dr. O'Connor's outpatient surgical practice, the market area will be somewhat smaller, primarily encompassing the east-central portions of DuPage County and the west-central portions of Cook County. The table on the following page identifies the ASTC's anticipated patient origin, following the addition of orthopedic surgery as a provided specialty.

The goal of the project is to initiate orthopedic surgery services at the ASTC within thirty days of receipt of the requested CON Permit.

ZIP Code	Community	%	Cum. %
60126	Elmhurst	13.2%	13.2%
60148	Lombard	8.6%	21.8%
60164	Melrose Park	5.3%	27.2%
60160	Melrose Park	4.5%	31.7%
60707	Elmwood Park	4.5%	36.2%
60104	Bellwood	3.7%	39.9%
60181	Villa Park	3.7%	43.6%
60171	River Grove	3.3%	46.9%
60106	Bensenville	3.3%	50.2%
60611	Chicago	2.9%	53.1%
60131	Franklin Park	2.5%	55.6%
60615	Chicago	2.5%	58.0%
60619	Chicago	2.5%	60.5%
	Other, < 2.5%	39.5%	100.0%

ATTACHMENT 12

ALTERNATIVES

This project is limited to the addition of a surgical specialty to a licensed ambulatory surgical treatment center. As a result of the project's limited scope, and consistent with consultation provided by HFSRB staff, a Certificate of Need Permit must be secured. Therefore, in order to comply with HFSRB requirements, the requested Permit must be secured.

PROJECT SERVICES UTILIZATION

Elmhurst Foot & Ankle Surgery Center was acquired by current ownership in late 2015, with a minimal amount of surgery being performed in the ASTC (known as Elmhurst Medical & Surgical Center prior to the change of ownership) during much of 2015. The ASTC has one operating room, one Stage 1 recovery station and two Stage 2 recovery stations. 161 hours of OR time were utilized in 2015 and 252 hours were utilized in 2016, the first full year under current ownership. With the requested addition of orthopedic surgery as a provided surgical specialty, utilization is anticipated to increase, substantially, as addressed in ATTACHMENT 25d.

Consistent with HFSRB practices, facilities are not required to meet minimum utilization standards for rooms or equipment when only a single room or piece of equipment is provided.

Dept./ Service	Historical Utilization (hours)	Projected Utilization (hours)		STATE STANDARD	MET STANDARD?
		YEAR 1	YEAR 2		
ASTC	252	486	486	N/A	N/A

The HFSRB does not maintain a utilization standard for recovery room stations.

GEOGRAPHIC SERVICE AREA NEED

The primary purpose of Elmhurst Foot & Ankle Surgery Center is, and will continue to be, to serve residents of the geographic service area ("GSA"), which is defined in Section 1110.1540 as the area within 45 minutes (adjusted) of the ASTC. That area extends (MapQuest 5/24/17 9:15AM):

- Northeast to Highland Park (Lake County)
- North to the Lake/Cook County line
- Northwest to Barrington (Cook County)
- West to the Kane/DuPage County line
- Southwest to Romeoville (Will County)
- South to Mokena (Will County)
- Southeast to Calumet City (Cook County
- East to Western Avenue in Chicago

Virtually all patients currently being referred to, and anticipated to be referred to Elmhurst Foot & Ankle Surgery Center are residents of the GSA. The table on the following page provides a combined patient origin analysis of patients referred to the ASTC and the surgical outpatients of Dr. Daryl O'Connor during 2016. Each ZIP Code area accounting for a minimum of 2.5% of the patient population described above is identified, with each of those ZIP Code areas being located in the GSA.

ZIP Code	Community	%	Cum. %
60126	Elmhurst	13.2%	13.2%
60148	Lombard	8.6%	21.8%
60164	Melrose Park	5.3%	27.2%
60160	Melrose Park	4.5%	31.7%
60707	Elmwood Park	4.5%	36.2%
60104	Bellwood	3.7%	39.9%
60181	Villa Park	3.7%	43.6%
60171	River Grove	3.3%	46.9%
60106	Bensenville	3.3%	50.2%
60611	Chicago	2.9%	53.1%
60131	Franklin Park	2.5%	55.6%
60615	Chicago	2.5%	58.0%
60619	Chicago	2.5%	60.5%
	Other, < 2.5%	39.5%	100.0%

ATTACHMENT 25c

SERVICE DEMAND

Elmhurst Foot & Ankle Surgery Center has one operating room, and it is not anticipated by the applicants that additional operating rooms will be added at any point in the foreseeable future. Therefore, and consistent with past HFSRB practices, as a single-OR facility, utilization standards are not applicable to this project.

During 2015, 162 hours of OR time were utilized at the ASTC. Utilization increased to 252 hours in 2016.

Upon the HFSRB's approval of orthopedic surgery as an allowable service at the ASTC, Dr. Daryl O'Connor, an orthopedic surgeon practicing in the area will begin referring patients to the ASTC, which will increase utilization, substantially. A letter, consistent with HFSRB requirements is attached. That letter states that, had Dr. O'Connor been able to do so, in 2016 he would have referred 175 patients to the ASTC. During 2017, orthopedic surgery cases performed HSA VII utilized, on average, 1.34 hours of OR time. Using that average, it is anticipated that the ASTC's utilization will increase by approximately 234 hours (175 x 1.34), annually, as a result of Dr. O'Connor receiving surgical privileges, and his anticipated referrals. Assuming the existing podiatric caseload to remain constant at the 2016 level of 252 hours (the first year following a HFSRB-approved change of ownership), utilization is anticipated to be approximately 486 hours during 2018. To remain conservative, no increase in utilization is anticipated between 2018 and 2019.

ATTACHMENT 25d

A letter from Dr. O'Connor, documenting anticipated referrals, and consistent with the requirements of Section 1110.1540.d, is attached.

Below is that anticipated patient origin of the ASTC (see discussion in ATTACHMENT 12), providing the patient information allowable under HIPPA limitations.

ZIP Code	Community	%	Cum. %
60126	Elmhurst	13.2%	13.2%
60148	Lombard	8.6%	21.8%
60164	Melrose Park	5.3%	27.2%
60160	Melrose Park	4.5%	31.7%
60707	Elmwood Park	4.5%	36.2%
60104	Bellwood	3.7%	39.9%
60181	Villa Park	3.7%	43.6%
60171	River Grove	3.3%	46.9%
60106	Bensenville	3.3%	50.2%
60611	Chicago	2.9%	53.1%
60131	Franklin Park	2.5%	55.6%
60615	Chicago	2.5%	58.0%
60619	Chicago	2.5%	60.5%
	Other, < 2.5%	39.5%	100.0%

Name (print): Daryl L. O'Connor, M.D.

Specialty: Orthopedic Surgery

TO: Illinois Health Facilities Planning Board
Springfield, Illinois

This letter is being provided in response to Review Criterion 1110.1540(c) in support of the proposed addition of orthopedic surgery as a specialty to be provided at Elmhurst Foot & Ankle Surgery Center in Elmhurst ("Elmhurst Foot & Ankle").

During 2016 I performed outpatient surgical procedures on approximately 200 patients in the facilities identified below.

Elmhurst Memorial Hospital	120 patients
Gottlieb Memorial Hospital	80 patients
	____ patients

I estimate that I would have referred 175 patients to Elmhurst Foot & Ankle in 2016, had orthopedic surgery been an approved service and had I received surgical privileges.

I further estimate that 98 % of my patients to use Elmhurst Foot & Ankle reside within the project's geographic service area/ 45 minutes of the proposed facility's site.

The information contained in this letter is true and correct, to the best of my information and belief, and has not been used in the support of another project.

Sincerely,

Notarized:

Susan M Lynch

SUSAN M LYNCH
Official Seal
Notary Public – State of Illinois
My Commission Expires May 9, 2021

ATTACHMENT 25d

TREATMENT ROOM NEED ASSESSMENT

Elmhurst Foot & Ankle Surgery Center has one operating room. Consistent with HFSRB practices, facilities are not required to meet minimum utilization standards for rooms or equipment when only a single room or piece of equipment is provided.

During 2016 145 podiatric surgery cases were performed at the ASTC. An additional 175 orthopedic surgery cases are anticipated in 2018, with the addition of Dr. Daryl O'Connor, and orthopedic surgeon, to the ASTC's medical staff (see ATTTACHMENT 25d). At minimum, it is projected that 486 hours of operating room time will be utilized during the second year following the addition of orthopedic surgery as an approved surgical specialty. This is a conservative estimate, in that it does not provide for the addition of any surgeons beyond those currently having privileges and Dr. O'Connor. The estimate above is based on the ASTC's historical time per podiatric surgery case and an estimate of 1.34 hours for orthopedic surgery cases, based on HSA VII-wide 2015 data.

ATTACHMENT 25f

SERVICE ACCESSIBILITY

The proposed project is limited to the addition of orthopedic surgery as a specialty to be provided at Elmhurst Foot & Ankle Surgery Center. Orthopedic surgery is a commonly-provided specialty in surgery centers, and as such, the project cannot achieve compliance with review criterion 1110.1540.g.

ATTACHMENT 25g

UNNECESSARY DUPLICATION/MALDISTRIBUTION

The proposed project is limited to the addition of orthopedic surgery as a specialty to be provided at Elmhurst Foot & Ankle Surgery Center. Orthopedic surgery is a commonly-provided specialty in surgery centers, and as such, the project cannot achieve compliance with review criterion 1110.1540.h.

The attached tables identify 39 hospitals and 24 ASTCs located within the defined GSA that provide outpatient orthopedic surgery to adults, as is being proposed through this application. Therefore, the addition of the service to Elmhurst Foot & Ankle Surgery Center will not result in an unnecessary duplication.

PROVIDERS OF ORTHOPEDIC SURGERY IN GSA HOSPITALS

Hospital	Location	Miles	Minutes
Elmhurst Memorial Hospital	Elmhurst	1.1	2
Adventist Hinsdale Hospital	Hisdale	6.4	12
Advocate Good Samaritan Hospital	Downers Grove	5.5	12
Loyola Univ. Med. Ctr./Foster G. McGaw	Maywood	7	13
Adventist LaGrange Memorial Hospital	LaGrange	7.3	18
VHS Westlake Hospital	Melrose Park	6.6	19
Rush Oak Park Hospital	Oak Park	6.9	19
Alexian Brothers Medical Center	Elk Grove Village	13.3	21
Loretto Hospital	Chicago	11	22
MacNeal Memorial Hospital	Berwyn	12	23
Gottlieb Memorial Hospital	Melrose Park	7.9	24
Adventist Glen Oaks Med. Ctr.	Glendale Heights	9.9	26
VHS West Suburban Med. Ctr.	Oak Park	11.8	28
Adventist Bolingbrook Hospital	Bolingbrook	17.9	30
Central DuPage Hospital	Winfield	12	31
Palos Community Hospital	Palos Heights	20	32
Advocate Christ Hospital & Health Ctr.	Oak Lawn	19.5	33
Presence Resurrection Med. Ctr.	Chicago	18.6	33
St. Alexius Medical Center	Hoffman Estates	21.1	33
Edward Hospital	Naperville	14.4	34
John H. Stroger Hospital of Cook Cty.	Chicago	15.7	34
Glenbrook Hospital	Glenview	25.4	34
Silver Cross Hospital	New Lenox	27	35
Mount Sinai Hospital Med. Ctr.	Chicago	15.4	36
St. Anthony Hospital	Chicago	15.8	36
Presence Mercy Center	Aurora	23.1	37
MetroSouth Medical Center	Blue Island	24.6	37
Ingalls Memorial Hospital	Harvey	28.1	37
Rush Copley Memorial Hospital	Aurora	22.3	39
Rush University Medical Center	Chicago	15.9	40
Little Company of Mary Hospital & Health Ctr.	Evergreen Park	21.5	40
St. Elizabeth's Hospital	Chicago	21.5	40
Advocate South Suburban Hospital	Hazel Crest	29.4	41
University of Illinois Hospital	Chicago	16.3	41
Adventist Bolingbrook Hospital	Bolingbrook	17.9	41
Northwest Community Hospital	Arlington Heights	16.3	42
Norwegian American Hospital	Chicago	16.1	44
Saint Mary of Nazareth Hospital	Chicago	17	44
Franciscan St. James Hospital & Health Ctr.	Olympia Fields	36	44

Note: Minutes adjusted by a factor of 1.10
May 23, 2017 3-4PM

ATTACHMENT 25h

PROVIDERS OF ORTHOPEDIC SURGERY IN GSA
AMBULATORY SURGICAL TREATMENT CENTERS

ASTC	Location	Miles	Minutes
Elmhurst Outpatient Surgery Center	Elmhurst	1.2	2
Loyola Amb. Surgery Center at Oakbrook	Oak Brook	3.7	6
DuPage Medical Group Surgery Center	Lombard	3.4	8
Hinsdale Surgical Center	Hinsdale	5.7	9
The Oak Brook Surgical Center	Oakbrook	3.1	10
Salt Creek Surgery Center	Westmont	4.6	11
Midwest Center for Day Surgery	Downers Grove	5.4	12
Loyola University Amb. Surg. Ctr.	Maywood	8.3	15
DuPage Orthopedic Group Surgery Center	Warrenville	14.1	21
The Center for Surgery	Naperville	12.2	21
Cadence Ambulatory Surgery Center	Warrenville	13.3	22
Novamed Surgery Center of Oak Lawn	Oak Lawn	17.1	22
Palos Hills Surgery Center	Palos Hills	17	22
Northwest Community Day Surg.	Arlington Heights	19.2	26
Northwest SurgiCare HealthSouth	Arlington Heights	18.8	26
Palos Surgicenter, LLC	Palos Heights	19.1	28
Illinois Sports Medicine & Orthopedic Surgery Ctr.	Morton Grove	19.9	29
Rush Surgicenter – Prof. Bldg.	Chicago	15.9	29
Dreyer Ambulatory Surgery Center	Aurora	23.2	32
Preferred Surgicenter, LLC	Orland Park	21.7	32
Naperville Surgical Centre	Naperville	17.4	35
Castle Surgicenter, LLC	Aurora	22.5	36
Hoffman Estates Surgery Center	Hoffman Estates	21.1	36
Edward Plainfield Surgery Center	Plainfield	28.8	39

Note: Minutes adjusted by a factor of 1.10
Mapquest 5/24/17 9:30-11AM

ATTACHMENT 25h

STAFFING

Due to the nature of the proposed project, no additional staff will need to be recruited or hired. Dr. Yvonne Burnett will continue in her current position as medical director of the ASTC.

CHARGE COMMITMENT

Attached is a copy of Elmhurst Foot & Ankle Surgery Center's current "charge master". With the filing of this Certificate of Need application, the applicants commit to maintaining the charges identified in the attached document for a minimum of two years following the proposed project's completion, unless a Permit is first obtained pursuant to 77 Ill. Adm. Code 1130.310(a).

ATTACHMENT 25j

CPT	Description	Fee
10022	FINE NEEDLE ASPIRATION WITH IMAGING GUIDANCE	$378.36
10061	INCISION&DRAINAGE ABSCESS COMPLICATED/MULTIPLE	$452.88
10081	INCISION & DRAINAGE PILONIDAL CYST COMPLICATED	$693.92
10121	INCISION&REMOVAL FOREIGN BODY SUBQ TISS COMP	$3,226.84
10180	INCISION&DRAINAGE COMPLEX PO WOUND INFECTION	$3,226.84
11010	DBRDMT W/RMVL FM FX&/DISLC SKN&SUBQ TISS	$2,149.20
11012	DBRDMT FX&/DISLC SUBQ T/M/F BONE	$3,226.84
11044	DBRDMT BONE M&/F 20 SQ CM/<	$2,149.20
11402	EXC B9 LES MRGN XCP SK TG T/A/L 1.1-2.0 CM	$439.72
11403	EXC B9 LES MRGN XCP SK TG T/A/L 2.1-3.0 CM	$477.72
11404	EXC B9 LES MRGN XCP SK TG T/A/L 3.1-4.0 CM	$2,149.20
11406	EXC B9 LES MRGN XCP SK TG T/A/L > 4.0 CM	$3,226.84
11421	EXC B9 LES MRGN XCP SK TG S/N/H/F/G .6-1CM	$400.00
11422	EXC B9 LES MRGN XCP SK TG S/N/H/F/G 1.1-2.0CM	$444.00
11423	EXC B9 LES MRGN XCP SK TG S/N/H/F/G 2.1-3.0CM	$484.00
11424	EXC B9 LES MRGN XCP SK TG S/N/H/F/G 3.1-4.0CM	$3,226.84
11426	EXC B9 LES MRGN XCP SK TG S/N/H/F/G > 4.0CM	$3,226.84
11626	EXCISION MALIGNANT LESION S/N/H/F/G > 4.0 CM	$3,226.84
11730	AVULSION OF NAIL PLATE, PARTIAL OR COMPLETE, SIMPLE;	$235.00
11750	EXCISION NAIL MATRIX PERMANENT REMOVAL	$498.16
11760	REPAIR NAIL BED	$978.04
11762	RECONSTRUCTION NAIL BED W/GRAFT	$698.28
11770	EXCISION PILONIDAL CYST/SINUS SIMPLE	$3,226.84
11960	INSERTION TISSUE EXPANDER INCL SBSQ XPNSJ	$4,876.88
12020	TX SUPERFICIAL WOUND DEHISCENCE SIMPLE CLOSURE	$978.04
13160	SEC CLSR SURG WOUND/DEHSN EXTENSIVE/COMPLICATED	$4,876.88
14040	ATT/REARRANGEMENT F/C/C/M/N/AX/G/H/F 10 CM/<	$3,219.76
14041	ATT/REARGMT F/C/C/M/N/AX/G/H/F 10.1-30.0CM	$3,219.76
15050	PINCH GRAFT 1/MLT C> SM ULCER TIP/OTH AREA 2CM	$978.04
15100	SPLIT AGRFT T/A/L 1ST 100 CM/</1% BDY INFT/CHLD	$4,876.88
15120	SPLIT AGRFT F/S/N/H/F/G/M/D GT 1ST 100 CM<1 %	$4,876.88
15200	FTH/GFT FREE W/DIRECT CLOSURE TRUNK 20 CM/<	$4,876.88
15240	FTH/GFT FR W/DIR CLSR F/C/C/M/N/AX/G/H/F 20 CM/<	$3,219.76
15271	APPLICATION OF SKIN SUBSTITUTE GRAFT FOOT	$3,219.76
17108	DESTRUCTION CUTANEOUS VASCULAR PRLF >50.0CM	$1,395.16
20005	I&D SOFT TISSUE ABSCESS SUBFASC	$3,226.84
20200	BIOPSY MUSCLE SUPERFICIAL	$3,226.84
20220	BIOPSY BONE TROCAR/NEEDLE SUPERFICIAL	$2,149.20
20240	BIOPSY BONE OPEN SUPERFICIAL	$3,226.84
20520	REMOVAL FOREIGN BODY MUSCLE/TENDON SHEATH SIMPLE	$530.32
20525	RMVL FOREIGN BODY MUSCLE/TENDON SHEATH DEEP/COMP	$3,226.84
20600	ARTHROCENTESIS, ASPIRATION AND/OR INJECTION; SMALL	$500.00
20670	REMOVAL IMPLANT SUPERFICIAL SPX	$3,226.84
20680	REMOVAL IMPLANT DEEP	$3,226.84

ATTACHMENT 25j

20690 APPLICATION UNIPLANE EXTERNAL FIXATION SYSTEM	$10,144.28
20692 APPLICATION MULTIPLANE EXTERNAL FIXATION SYSTEM	$14,414.12
20693 ADJUSTMENT/REVJ XTRNL FIXATION SYSTEM REQ ANES	$5,465.76
20694 REMOVAL EXTERNAL FIXATION SYSTEM UNDER ANES	$3,320.32
20900 BONE GRAFT ANY DONOR AREA MINOR/SMALL	$5,465.76
20902 BONE GRAFT ANY DONOR AREA MAJOR/LARGE	$14,414.12
20924 TENDON GRAFT FROM A DISTANCE	$5,465.76
20926 TISSUE GRAFTS OTHER	$4,876.88
27603 INCISION&DRAINAGE LEG/ANKLE ABSCESS/HEMATOMA	$3,226.84
27604 INCISION&DRAINAGE LEG/ANKLE INFECTED BURSA	$5,465.76
27605 TENOTOMY PRQ ACHILLES TENDON SPX LOCAL ANES	$3,320.32
27606 TENOTOMY PRQ ACHILLES TENDON SPX GENERAL ANES	$5,465.76
27607 INCISION LEG/ANKLE	$5,465.76
27610 ARTHROTOMY ANKLE W/EXPL DRAINAGE/REMOVAL FB	$5,465.76
27612 ARTHRT PST CAPSULAR RLS ANKLE +-ACHLL TDN LNGTH	$5,465.76
27613 BIOPSY SOFT TISSUE LEG/ANKLE AREA SUPERFICIAL	$685.16
27614 BIOPSY SOFT TISSUE LEG/ANKLE AREA DEEP	$3,226.84
27615 RAD RESECTION TUMOR SOFT TISSUE LEG/ANKLE <5CM	$3,226.84
27616 RAD RESCJ TUM SOFT TISSUE LEG/ANKLE 5+CM	$3,226.84
27618 EXC TUMOR SOFT TISSUE LEG/ANKLE SUBQ <3CM	$3,226.84
27619 EXC TUMOR SOFT TISSUE LEG/ANKLE SUBFASCIAL <5CM	$3,226.84
27620 ARTHRT ANKLE W/JT EXPL +-BX +-RMVL LOOSE/FB	$5,465.76
27625 ARTHROTOMY W/SYNOVECTOMY ANKLE	$5,465.76
27626 ARTHROTOMY W/SYNOVECTOMY ANKLE TENOSYNOVECTOMY	$5,465.76
27630 EXCISION LESION TENDON SHEATH/CAPSULE LEG&/ANKLE	$3,320.32
27632 EXCISION TUMOR SOFT TISSUE LEG/ANKLE SUBQ 3+ CM	$3,226.84
27634 EXC TUMOR SOFT TISSUE LEG/ANKLE SUBFASC 5+CM	$3,226.84
27635 EXCISION/CURETTAGE BONE CYST/TUMOR TIBIA/FIBULA	$5,465.76
27637 EXC/CURETTAGE CYST/TUMOR TIBIA/FIBULA W/AGRAFT	$10,144.28
27638 EXC/CURETTAGE CYST/TUMOR TIBIA/FIBULA W/ALGRAFT	$10,144.28
27640 PARTIAL EXCISION BONE TIBIA	$5,465.76
27641 PARTIAL EXCISION BONE FIBULA	$5,465.76
27647 RADICAL RESECTION OF TUMOR TALUS OR CALCANEUS	$3,320.32
27650 REPAIR PRIMARY OPEN/PRQ RUPTURED ACHILLES TENDON	$5,465.76
27652 RPR PRIMARY OPEN/PRQ RUPTURED ACHILLES W/GRAFT	$10,144.28
27654 REPAIR SECONDARY ACHILLES TENDON +-GRAFT	$10,144.28
27656 REPAIR FASCIAL DEFECT LEG	$5,465.76
27658 REPAIR FLEXOR TENDON LEG PRIMARY W/O GRAFT EACH	$5,465.76
27659 RPR FLEXOR TENDON LEG SECONDARY W/O GRAFT EACH	$5,465.76
27664 RPR EXTENSOR TENDON LEG PRIMARY W/O GRAFT EACH	$5,465.76
27665 RPR EXTENSOR TENDON LEG SECONDARY +/-GRAFT EACH	$10,144.28
27675 RPR DISLOCATING PERONEAL TENDON W/O FIB OSTEOT	$5,465.76
27676 REPAIR DISLOCATING PERONEAL TENDON W/FIB OSTEOT	$5,465.76
27680 TENOLYSIS FLXR/XTNSR TENDON LEG&/ANKLE 1 EACH	$5,465.76
27681 TNOLS FLXR/XTNSR TDN LEG&/ANKLE MLT TDN	$5,465.76

ATTACHMENT 25j

27685 LNGTH/SHRT TDN LEG/ANKLE 1 TDN SPX	$5,465.76
27686 LNGTH/SHRT TDN LEG/ANKLE MLT TDN SAME INC EA	$5,465.76
27687 GASTROCNEMIUS RECESSION	$5,465.76
27690 TR/TRNSPL 1 TDN W/MUSC REDIRION/REROUTING SUPFC	$5,465.76
27691 TR/TRNSPL 1 TDN W/MUSC REDIRION/REROUTING DP	$5,465.76
27695 RPR PRIMARY DISRUPTED LIGAMENT ANKLE COLLATERAL	$5,465.76
27696 RPR PRIM DISRUPTED LIGM ANKLE BTH COLTRL LIGMS	$5,465.76
27698 REPAIR SECONDARY DISRUPTED LIGAMENT ANKLE COLTRL	$5,465.76
27700 ARTHROPLASTY ANKLE	$10,144.28
27704 REMOVAL ANKLE IMPLANT	$5,465.76
27705 OSTEOTOMY TIBIA	$5,465.76
27707 OSTEOTOMY FIBULA	$5,465.76
27709 OSTEOTOMY TIBIA&FIBULA	$14,414.12
27720 REPAIR NONUNION/MALUNION TIBIA W/O GRAFT	$10,144.28
27726 REPAIR FIBULA NONUNION/MALUNION W INT FIXATION	$10,144.28
27730 ARREST EPIPHYSEAL OPEN DISTAL TIBIA	$5,465.76
27732 ARREST EPIPHYSEAL OPEN DISTAL FIBULA	$5,465.76
27734 ARREST EPIPHYSEAL OPEN DISTAL TIBIA&FIBULA	$5,465.76
27740 ARRST EPIPHYSL ANY METH TIBFIB	$5,465.76
27742 ARRST EPIPHYSL ANY METH TIBFIB&DSTL FEMUR	$5,465.76
27745 PROPH TX N/P/PLTWR +-MMA TIBIA	$14,414.12
27750 CLTX TIBL SHFT FX W/O MNPJ	$541.84
27752 CLTX TIBL SHFT FX W/MNPJ +-SKEL TRACJ	$2,501.64
27756 PRQ SKEL FIXJ TIBL SHFT FX	$10,144.28
27758 OPTX TIBL SHFT FX W/PLATE/SCREWS +-CERCLAGE	$14,414.12
27759 TX TIBL SHFT FX IMED IMPLT +-SCREWS&/CERCLAGE	$14,414.12
27760 CLTX MEDIAL MALLS FX W/O MNPJ	$393.20
27762 CLTX MEDIAL MALLS FX W/MNPJ +-SKN/SKEL TRACJ	$2,501.64
27766 OPEN TREATMENT MEDIAL MALLEOLUS FRACTURE	$5,465.76
27767 CLOSED TREATMENT PST MALLEOLUS FRACTURE W/O MNPJ	$541.84
27768 CLOSED TREATMENT PST MALLEOLUS FRACTURE W MNPJ	$2,501.64
27769 OPEN TREATMENT POSTERIOR MALLEOLUS FRACTURE	$10,144.28
27780 CLTX PROX FIBULA/SHFT FX W/O MNPJ	$393.20
27781 CLTX PROX FIBULA/SHFT FX W/MNPJ	$2,501.64
27784 OPEN TREATMENT PROXIMAL FIBULA/SHAFT FRACTURE	$10,144.28
27786 CLTX DSTL FIBULAR FX LAT MALLS W/O MNPJ	$541.84
27788 CLTX DSTL FIBULAR FX LAT MALLS W/MNPJ	$541.84
27792 OPEN TX DISTAL FIBULAR FRACTURE LAT MALLEOLUS	$10,144.28
27808 CLOSED TX BIMALLEOLAR ANKLE FRACTURE W/O MNPJ	$393.20
27810 CLOSED TX BIMALLEOLAR ANKLE FRACTURE W MNPJ	$2,501.64
27814 OPEN TREATMENT BIMALLEOLAR ANKLE FRACTURE	$10,144.28
27816 CLTX TRIMAL ANKLE FX W/O MNPJ	$541.84
27818 CLTX TRIMAL ANKLE FX W/MNPJ	$2,501.64
27822 OPEN TX TRIMALLEOLAR ANKLE FX W/O FIXJ PST LIP	$10,144.28
27823 OPEN TX TRIMALLEOLAR ANKLE FX W FIXJ PST LIP	$14,414.12

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27824 CLTX FX W8 BRG ARTCLR PRTN DSTL TIBIA W/O MNPJ	$541.84
27825 CLTX FX W8 BRG ARTCLR PRTN DSTL TIB W/SKEL TRACJ	$2,501.64
27826 OPEN TREATMENT FRACTURE DISTAL TIBIA FIBULA	$10,144.28
27827 OPEN TREATMENT FRACTURE DISTAL TIBIA ONLY	$14,414.12
27828 OPEN TREATMENT FRACTURE DISTAL TIBIA & FIBULA	$14,414.12
27829 OPEN TX DISTAL TIBIOFIBULAR JOINT DISRUPTION	$5,465.76
27830 CLTX PROX TIBFIB JT DISLC W/O ANES	$393.20
27831 CLTX PROX TIBFIB JT DISLC REQ ANES	$2,501.64
27832 OPEN TX PROX TIBFIB JOINT DISLOCATE EXC PROX FIB	$10,144.28
27840 CLOSED TX ANKLE DISLOCATION W/O ANESTHESIA	$393.20
27842 CLTX ANKLE DISLC REQ ANES +-PRQ SKEL FIXJ	$2,501.64
27846 OPTX ANKLE DISLC W/O RPR/INT FIXJ	$5,465.76
27848 OPTX ANKLE DISLC W/RPR/INT/XTRNL FIXJ	$5,465.76
27860 MNPJ ANKLE UNDER GENERAL ANES	$2,501.64
27870 ARTHRODESIS ANKLE OPEN	$32,179.12
27871 ARTHRODESIS TIBIOFIBULAR JOINT PROXIMAL/DISTAL	$14,414.12
27884 AMP LEG THRU TIBIA&FIBULA SEC CLOSURE/SCAR REVJ	$5,465.76
27889 ANKLE DISARTICULATION	$5,465.76
27892 DCMPRN FASCT LEG ANT&/LAT W/DBRDMT MUSC&/NRV	$5,465.76
27893 DCMPRN FASCT LEG PST W/DBRDMT MUSC&/NRV	$5,465.76
27894 DCMPRN FASCT LEG ANT&/LAT&PST W/DBRDMT MUSC&/NRV	$3,320.32
28001 INCISION&DRAINAGE BURSA FOOT	$727.56
28002 I&D BELW FSCA FOOT 1 BURSAL SPACE	$3,320.32
28003 I&D BELW FSCA FOOT MLT AREAS	$3,320.32
28005 INCISION BONE CORTEX FOOT	$5,465.76
28008 FASCIOTOMY FOOT&/TOE	$3,320.32
28010 TENOTOMY PERCUTANEOUS TOE SINGLE TENDON	$501.08
28011 TENOTOMY PERCUTANEOUS TOE MULTIPLE TENDON	$3,320.32
28020 ARTHRT W/EXPL DRG/RMVL LOOSE/FB NTRTRSL/TARS JT	$5,465.76
28022 ARTHRT W/EXPL DRG/RMVL LOOSE/FB MTTARPHLNGL JT	$5,465.76
28024 ARTHRT W/EXPL DRG/RMVL LOOSE/FB IPHAL JT	$3,320.32
28035 RELEASE TARSAL TUNNEL	$3,177.24
28039 EXCISION TUMOR SOFT TISSUE FOOT/TOE SUBQ 1.5+CM	$3,226.84
28041 EXC TUMOR SOFT TISSUE FOOT/TOE SUBFASC 1.5+CM	$3,226.84
28043 EXCISION TUMOR SOFT TISSUE FOOT/TOE SUBQ <1.5CM	$3,226.84
28045 EXC TUMOR SOFT TISSUE FOOT/TOE SUBFASC <1.5CM	$3,226.84
28046 RAD RESECTION TUMOR SOFT TISSUE FOOT/TOE <3CM	$3,226.84
28047 RAD RESECTION TUMOR SOFT TISSUE FOOT/TOE 3+CM	$3,226.84
28050 ARTHRT W/BX INTERTARSAL/TARS JT	$3,320.32
28052 ARTHRT W/BX METATARSOPHALANGEAL JT	$3,320.32
28054 ARTHRT W/BX IPHAL JT	$3,320.32
28055 NEURECTOMY INTRINSIC MUSCULATURE OF FOOT	$3,177.24
28060 FASCIECTOMY PLANTAR FASCIA PARTIAL SPX	$3,320.32
28062 FASCIOTOMY PLANTAR FASCIA RADICAL SPX	$5,465.76
28070 SYNVCT INTERTARSAL/TARSOMETATARSAL JT EA SPX	$3,320.32

ATTACHMENT 25j

28072 SYNOVECTOMY METATARSOPHALANGEAL JOINT EACH	$3,320.32
28080 EXCISION INTERDIGITAL MORTON NEUROMA SINGLE EACH	$3,320.32
28086 SYNOVECTOMY TENDON SHEATH FOOT FLEXOR	$5,465.76
28088 SYNOVECTOMY TENDON SHEATH FOOT EXTENSOR	$3,320.32
28090 EXC LESION TENDON SHEATH/CAPSULE W/SYNVCT FOOT	$3,320.32
28092 EXC LESION TENDON SHEATH/CAPSULE W/SYNVCT TOE EA	$3,320.32
28100 EXCISION/CURETTAGE CYST/TUMOR TALUS/CALCANEUS	$5,465.76
28102 EXC/CURTG CST/B9 TUM TALUS/CLCNS W/ILIAC/AGRFT	$10,144.28
28103 EXC/CURETTAGE CYST/TUMOR TALUS/CALCANEUS ALGRFT	$10,144.28
28104 EXC/CURTG CST/B9 TUM TARSAL/METAR	$3,320.32
28106 EXC/CURTG CST/B9 TUM TARSAL/METAR W/ILIAC/AGRFT	$5,465.76
28107 EXC/CURTG CST/B9 TUM TARSAL/METAR W/ALGRFT	$10,144.28
28108 EXC/CURTG CST/B9 TUM PHALANGES FOOT	$3,320.32
28110 OSTECTOMY PRTL 5TH METAR HEAD SPX	$3,320.32
28111 OSTECTOMY COMPLETE 1ST METATARSAL HEAD	$3,320.32
28112 OSTECTOMY COMPLETE OTHER METATARSAL HEAD 2/3/4	$3,320.32
28113 OSTECTOMY COMPLETE 5TH METATARSAL HEAD	$3,320.32
28114 OSTC COMPL ALL METAR HEADS W/PRTL PROX PHALANGC	$5,465.76
28116 OSTECTOMY TARSAL COALITION	$3,320.32
28118 OSTECTOMY CALCANEUS	$5,465.76
28119 OSTECTOMY CALCANEUS SPUR +-PLNTAR FSCAL RLS	$5,465.76
28120 PRTL EXC B1 TALUS/CALCANEUS	$5,465.76
28122 PRTL EXC B1 TARSAL/METAR B1 XCP TALUS/CALCANEUS	$3,320.32
28124 PRTL EXC B1 PHALANX TOE	$1,224.24
28126 RESECTION PARTIAL/COMPLETE PHALANGEAL BASE EACH	$3,320.32
28130 TALECTOMY ASTRAGALECTOMY	$5,465.76
28140 METATARSECTOMY	$3,320.32
28150 PHALANGECTOMY TOE EA TOE	$3,320.32
28153 RESECTION CONDYLE DISTAL END PHALANX EACH TOE	$3,320.32
28160 HEMIPHALANGC/IPHAL JT EXC TOE	$3,320.32
28171 RAD RESCJ TUMOR TARSAL EXCEPT TALUS/CALCANEUS	$3,320.32
28173 RADICAL RESECTION TUMOR METATARSAL	$3,320.32
28175 RADICAL RESECTION TUMOR PHALANX OR TOE	$3,320.32
28190 REMOVAL FOREIGN BODY FOOT SUBCUTANEOUS	$764.04
28192 REMOVAL FOREIGN BODY FOOT DEEP	$3,226.84
28193 REMOVAL FOREIGN BODY FOOT COMPLICATED	$3,226.84
28200 RPR TDN FLXR FOOT 1/2 W/O FR GRF EA TDN	$5,465.76
28202 RPR TDN FLXR FOOT SEC W/FR GRF EA TDN	$10,144.28
28208 RPR TDN XTNSR FOOT 1/2 EA TDN	$5,465.76
28210 RPR TDN XTNSR FOOT SEC W/FR GRF EA TDN	$3,320.32
28220 TENOLYSIS FLEXOR FOOT SINGLE TENDON	$5,465.76
28222 TENOLYSIS FLEXOR FOOT MULTIPLE TENDONS	$3,320.32
28225 TENOLYSIS EXTENSOR FOOT SINGLE TENDON	$3,320.32
28226 TENOLYSIS EXTENSOR FOOT MULTIPLE TENDON	$3,320.32
28230 TX OPN TDN FLXR FOOT 1/MLT TDN SPX	$1,126.32

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28232 TX OPN TDN FLXR TOE 1 TDN SPX	$1,063.56
28234 TENOTOMY OPEN EXTENSOR FOOT/TOE EACH TENDON	$3,320.32
28238 RCNSTJ PST TIBL TDN W/EXC ACCESSORY TARSL NAVCLR	$5,465.76
28240 TENOTOMY LENGTHENING/RLS ABDUCTOR HALLUCIS MUSC	$3,320.32
28250 DIVISION PLANTAR FASCIA&MUSCLE SPX	$5,465.76
28260 CAPSULOTOMY MIDFOOT MEDIAL RELEASE ONLY SPX	$3,320.32
28261 CAPSULOTOMY MIDFOOT W/TENDON LENGTHENING	$5,465.76
28262 CAPSUL MIDFOOT W/PST TALOTIBL CAPSUL&TDN LNGTH	$10,144.28
28264 CAPSULOTOMY MIDTARSAL	$3,320.32
28270 CAPSUL MTTARPHLNGL JT +-TENORRHAPHY EA JT SPX	$3,320.32
28272 CAPSUL IPHAL JT EA JT SPX	$1,050.36
28280 SYNDACTYLIZATION TOES	$3,320.32
28285 CORRECTION HAMMERTOE	$3,320.32
28286 CORRECTION COCK-UP 5TH TOE W/PLASTIC CLOSURE	$3,320.32
28288 OSTC PRTL EXOSTC/CONDYLC METAR HEAD	$3,320.32
28289 HALLUX RGDUS CORRJ W/CHEILC	$5,465.76
28290 CORRJ HALLUX VALGUS +-SESMDC SMPL EXOSTECTOMY	$5,465.76
28291 CORRJ HALUX RIGDUS W/IMPLT	$6,225.00
28292 KELLER/MCBRIDE/MAYO PROCEDURE	$5,465.76
28293 CORRJ HALLUX VALGUS +-SESMDC RESCJ JT W/IMPLT	$10,144.28
28294 CORRJ HALLUX VALGUS +-SESMDC W/TDN TRNSPLS	$5,465.76
28295 CORRECTION HALLUX VALGUS	$2,865.00
28296 CORRJ HALLUX VALGUS +-SESMDC W/METAR OSTEOT	$5,465.76
28297 CORRJ HALLUX VALGUS +-SESMDC LAPIDUS-TYP PX	$14,414.12
28298 CORRJ HALLUX VALGUS +-SESMDC PHALANX OSTEOT	$5,465.76
28299 CORRJ HALLUX VALGUS +-SESMDC 2 OSTEOT	$5,465.76
28300 OSTEOTOMY CALCANEUS +-INTERNAL FIXATION	$10,144.28
28302 OSTEOTOMY TALUS	$5,465.76
28304 OSTEOTOMY TARSAL BONES OTH/THN CALCANEUS/TALUS	$10,144.28
28305 OSTEOT TARSAL OTH/THN CALCANEUS/TALUS W/AGRFT	$10,144.28
28306 OSTEOT +-LNGTH SHRT/CORRJ 1ST METAR	$5,465.76
28307 OSTEOT +-LNGTH SHRT/CORRJ 1ST METAR XCP 1ST TOE	$5,465.76
28308 OSTEOT +-LNGTH SHRT/CORRJ METAR XCP 1ST EA	$5,465.76
28309 OSTEOT +-LNGTH SHRT/ANGULAR CORRJ METAR MLT	$10,144.28
28310 OSTEOT SHRT CORRJ PROX PHALANX 1ST TOE	$5,465.76
28312 OSTEOT SHRT CORRJ OTH PHALANGES ANY TOE	$5,465.76
28313 RCNSTJ ANGULAR DFRM TOE SOFT TISS PX ONLY	$3,320.32
28315 SESAMOIDECTOMY FIRST TOE SPX	$3,320.32
28320 REPAIR NONUNION/MALUNION TARSAL BONES	$14,414.12
28322 RPR NON/MAL METAR +-B1 GRF	$10,144.28
28340 RCNSTJ TOE MACRODACTYLY SOFT TISSUE RESECTION	$3,320.32
28341 RCNSTJ TOE MACRODACTYLY REQUIRING BONE RESECTION	$3,320.32
28344 RECONSTRUCTION TOE POLYDACTYLY	$5,465.76
28345 RCNSTJ TOE SYNDACTYLY +-SKN GRF EA WEB	$3,320.32
28400 CLOSED TX CALCANEAL FRACTURE W/O MANIPULATION	$541.84

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28405 CLOSED TX CALCANEAL FRACTURE W/MANIPULATION	$541.84
28406 PRQ SKEL FIXJ CALCANEAL FX W/MNPJ	$5,465.76
28415 OPEN TREATMENT CALCANEAL FRACTURE	$14,414.12
28420 OPEN TREATMENT CALCANEAL FRACTURE W BONE GRAFT	$32,179.12
28430 CLOSED TX TALUS FRACTURE W/O MANIPULATION	$393.20
28435 CLOSED TX TALUS FRACTURE W/ MANIPULATION	$2,501.64
28436 PRQ SKELETAL FIXATION TALUS FRACTURE W/MNPJ	$5,465.76
28445 OPEN TREATMENT TALUS FRACTURE	$10,144.28
28446 OPEN OSTEOCHONDRAL AUTOGRAFT TALUS	$10,144.28
28450 TX TARSAL B1 FX XCP TALUS&CALCN W/O MNPJ	$541.84
28455 TX TARSAL B1 FX XCP TALUS&CALCN W/MNPJ	$683.68
28456 PRQ SKEL FIXJ TARSL FX XCP TALUS&CALCNS W/MNPJ	$14,414.12
28465 OPEN TX TARSAL FRACTURE XCP TALUS &CALCANEUS EA	$10,144.28
28470 CLOSED TX METATARSAL FRACTURE W/O MANIPULATION	$393.20
28475 CLTX METAR FX W/MNPJ	$393.20
28476 PRQ SKEL FIXJ METAR FX W/MNPJ	$5,465.76
28485 OPEN TREATMENT METATARSAL FRACTURE EACH	$5,465.76
28490 CLTX FX GRT TOE PHLX/PHLG W/O MNPJ	$393.20
28495 CLTX FX GRT TOE PHLX/PHLG W/MNPJ	$393.20
28496 PRQ SKEL FIXJ FX GRT TOE PHLX/PHLG W/MNPJ	$5,465.76
28505 OPEN TX FRACTURE GREAT TOE/PHALANX/PHALANGES	$5,465.76
28510 CLTX FX PHLX/PHLG OTH/THN GRT TOE W/O MNPJ	$325.76
28515 CLTX FX PHLX/PHLG OTH/THN GRT TOE W/MNPJ	$423.64
28525 OPEN TX FRACTURE PHALANX/PHALANGES NOT GREAT TOE	$5,465.76
28530 CLOSED TREATMENT SESAMOID FRACTURE	$306.80
28531 OPEN TX SESAMOID FRACTURE +-INTERNAL FIXATION	$5,465.76
28540 CLTX TARSAL DISLC OTH/THN TALOTARSAL W/O ANES	$393.20
28545 CLTX TARSAL DISLC OTH/THN TALOTARSAL W/ANES	$5,465.76
28546 PRQ SKEL FIXJ TARSL DISLC XCP TALOTARSAL W/MNPJ	$3,320.32
28555 OPEN TREATMENT TARSAL BONE DISLOCATION	$14,414.12
28570 CLOSED TX TALOTARSAL JOINT DISLC W/O ANES	$393.20
28575 CLOSED TX TALOTARSAL JOINT DISLOCATION W/ANES	$2,501.64
28576 PRQ SKEL FIXJ TALOTARSAL JT DISLC W/MNPJ	$3,320.32
28585 OPEN TREATMENT TALOTARSAL JOINT DISLOCATION	$5,465.76
28600 CLOSED TX TARSOMETATARSAL DISLOCATION W/O ANES	$541.84
28605 CLOSED TX TARSOMETATARSAL DISLOCATION W/ANES	$393.20
28606 PRQ SKEL FIXJ TARS JT DISLC W/MNPJ	$5,465.76
28615 OPEN TREATMENT TARSOMETATARSAL JOINT DISLOCATION	$10,144.28
28630 CLTX METATARSOPHLNGL JT DISLC W/O ANES	$369.60
28635 CLTX METATARSOPHLNGL JT DISLC REQ ANES	$2,501.64
28636 PRQ SKEL FIXJ METATARSOPHLNGL JT DISLC W/MNPJ	$5,465.76
28645 OPEN TX METATARSOPHALANGEAL JOINT DISLOCATION	$5,465.76
28660 CLTX IPHAL JT DISLC W/O ANES	$274.64
28665 CLTX IPHAL JT DISLC REQ ANES	$474.28
28666 PRQ SKEL FIXJ IPHAL JT DISLC W/MNPJ	$5,465.76

28675	OPEN TREATMENT INTERPHALANGEAL JOINT DISLOCATION	$3,320.32
28705	ARTHRODESIS PANTALAR	$32,179.12
28715	ARTHRODESIS TRIPLE	$32,179.12
28725	ARTHRODESIS SUBTALAR	$14,414.12
28730	ARTHRD MIDTARSL/TARS MLT/TRANSVRS	$14,414.12
28735	ARTHRD MIDTARSL/TARS MLT/TRANSVRS W/OSTEOT	$32,179.12
28737	ARTHRD W/TDN LNGTH&ADVMNT TARSL NVCLR-CUNEIFORM	$14,414.12
28740	ARTHRODESIS MIDTARSOMETATARSAL SINGLE JOINT	$14,414.12
28750	ARTHRODESIS GREAT TOE METATARSOPHALANGEAL JOINT	$10,144.28
28755	ARTHRODESIS GREAT TOE INTERPHALANGEAL JOINT	$5,465.76
28760	ARTHRD W/XTNSR HALLUCIS LONGUS TR 1ST METAR NCK	$10,144.28
28810	AMPUTATION METATARSAL W/TOE SINGLE	$3,320.32
28820	AMPUTATION TOE METATARSOPHALANGEAL JOINT	$3,320.32
28825	AMPUTATION TOE INTERPHALANGEAL JOINT	$3,320.32
28890	ESWT HI NRG PFRMD PHYS W/US GDN INVG PLNTAR FSCA	$812.24
29345	APPLICATION LONG LEG CAST THIGH-TOE	$330.16
29405	APPLICATION SHORT LEG CAST BELOW KNEE-TOE	$208.92
29730	WINDOWING CAST	$144.64
29740	WEDGING CAST EXCEPT CLUBFOOT CASTS	$220.56
29750	WEDGING CLUBFOOT CAST	$168.00
29891	ARTHRS ANKLE EXC OSTCHNDRL DFCT W/DRLG DFCT	$5,465.76
29892	ARTHRS AID RPR LES/TALAR DOME FX/TIBL PLAFOND FX	$5,465.76
29893	ENDOSCOPIC PLANTAR FASCIOTOMY	$3,320.32
29894	ARTHROSCOPY ANKLE W/REMOVAL LOOSE/FOREIGN BODY	$5,465.76
29895	ARTHROSCOPY ANKLE SURGICAL SYNOVECTOMY PARTIAL	$5,465.76
29897	ARTHROSCOPY ANKLE SURGICAL DEBRIDEMENT LIMITED	$5,465.76
29898	ARTHROSCOPY ANKLE SURGICAL DEBRIDEMENT EXTENSIVE	$5,465.76
29899	ARTHROSCOPY ANKLE SURGICAL W/ANKLE ARTHRODESIS	$14,414.12
29904	ARTHRS SUBTALAR JOINT REMOVE LOOSE/FOREIGN BODY	$5,465.76
29905	ARTHROSCOPY SUBTALAR JOINT WITH SYNOVECTOMY	$5,465.76
29906	ARTHROSCOPY SUBTALAR JOINT WITH DEBRIDEMENT	$3,320.32
29907	ARTHROSCOPY SUBTALAR JOINT SUBTALAR ARTHRODESIS	$14,414.12
64450	N BLOCK OTHER PERIPHERAL	$215.00
64704	NEUROLYSIS FOOT	$3,177.24
64726	INT NEUROLSS REQ MCRSCP	$3,177.24
64782	EXC NEUROMA HAND/FOOT EA NRV XCP SM DGT	$3,177.24
76000	FLUOROSCOPE EXAMINATION	$180.00
76881	US XTR NON-VASC COMPLETE	$400.00
76942	U/S GUIDED INJECTION	$170.00
82947	ASSAY GLUCOSE BLOOD QUANT	$50.00
84702	HCG TEST	$50.00
ANCHOR	ANCHOR (MITEK, CORKSCREW)	$0.00
C1713	ANCHOR/SCREW BN/BN,TIS/BN	$0.01
C1762	CONN TISS, HUMAN(INC FASCIA)	$0.01
G8907	PATIENT DID NOT EXPERIENCE ANY CONDITIONS	$0.01

ATTACHMENT 25j

G8908	PATIENT RECEIVED A BURN PRIOR TO DISCHARGE	$0.01
G8909	PATIENT DID NOT RECEIVE A BURN PRIOR TO DISCHARGE	$0.01
G8910	PATIENT FELL WITHIN ASC	$0.01
G8911	PATIENT DID NOT FALL WITHIN ASC	$0.01
G8912	PATIENT WRONG SIDE/SITE/PROCEDURE/IMPLANT	$0.01
G8913	PATIETN NO WRONG SIDE/SITE/PROCEDURE/IMPLANT	$0.01
G8914	PATIENT HAD HOSPITAL TRANSFER/ADMISSION	$0.01
G8915	PATIENT HAD NO HOSPITAL TRANSFER/ADMISSION	$0.01
G8916	PATIENT HAD ANTIBIOTICS ON TIME W/PREP	$0.01
G8917	PATIENT NO ANTIBIOTICS ON TIME W/PREOP	$0.01
G8918	PATIENT W/O PREOP ORDER FOR ANTIBIOTICS	$0.01
IMPHT	IMPLANT: HAMMER TOE	$0.00
IMPSPEC	IMPLANT: SPECIAL ORDER	$0.00
IMPSWA	IMPLANT: SWANSON 1ST MPJ	$0.00
L8699	PROSTHETIC IMPLANT NOS	$0.01
MISCMR	MEDICAL RECORD COPY	$25.00
MISCNSF	INSUFFICIENT FUNDS	$30.00
PLATE5	PLATE: 5 HOLE OR LESS	$0.00
PLATE6	PLATE: 6 HOLE OR MORE	$0.00
PLATELA	PLATE: LAPIDUS	$0.00
PLATESP	PLATE: SPECIAL ORDER	$0.00
SCREWH	SCREW: HEADED (2.0MM TO 4.0MM)	$0.00
SCREWH	SCREW: HEADED (4.5MM TO 8.0MM)	$0.00
SCREWH	SCREW: HEADLESS (2.0MM TO 4.0MM)	$0.00
SCREWH	SCREW: HEADLESS (4.5MM TO 8.0MM)	$0.00
SCREWS	SCREW: SPECIAL ORDER	$0.00

ASSURANCES

With the filing of this Certificate of Need application, the applicants attest that Elmhurst Foot & Ankle Surgery Center maintains a peer review program, consistent with appropriate standards and outcome follow-up. Copies of the forms used in the implementation of that program are attached.

Because Elmhurst Foot & Ankle Surgery Center has only one operating room, the HFSRB's utilization standard (hours per OR) is not applicable.

Clinical Policies and Procedures Manual

SECTION: RC/ Record of Care, Treatment and Services
TITLE: MEDICAL RECORD DEPARTMENT PERFORMANCE IMPROVEMENT PARTICIPATION
PAGE: 1 of 1
EFFECTIVE DATE: 03/23/11
REVISION DATE:

As part of the facility-wide Performance Improvement program, medical records are routinely reviewed for completeness. Daily chart analysis is done documenting repeated omissions, errors, etc., for referral to the Manager who works with the Quality Council, and when necessary, medical staff to correct procedures and practices.

The nursing staff reviews 100 percent of the completed records prior to filing in the complete files.

The Medical Executive Committee quarterly reviews a random sampling of medical records for complete and appropriate documentation, and peer review.

ATTACHMENT 25k

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Peer Review Summary Form ~ EFASC

4th Quarter (YEAR)

If any items were idantified from the peer review form as being deficient, please tally and keep record to be used during tha re-appointment process.

Anesthesiologist Name	Pre-induction assessment noted	Choice of Anesthesia appropraite	Absence of adverse drug reactions	Vital signs complete	Patient status recorded on transfer to PACU	Anesthesia orders signed	Total cases reviewed for quarter
Totals	0	0	0	0	0	0	0

ATTACHMENT 25k

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Elmhurst Foot & Ankle Surgery Center

Chart Number:	***Doctor:***
Date of Service:	

ATTACHMENT 25k

PHYSICIAN PEER REVIEW

		YES	NO	N/A
1	History and Physical present and within 30 day timeline			
2	Operative note present on chart and sufficient. (AT END OF PROCEDURE PRIOR TO SURGEON LEAVING PREMISES).			
3	Surgeon note (operative report) sufficient to indicate surgery.			
4	PATHOLOGY: Specimen removal indicated.			
5	COMPLICATIONS: Management appropriate.			
6	Discharge note/orders present and sufficient.			
7	UTILIZATION REVIEW: Appropriate setting for this surgery.			
8	UTILIZATION REVIEW: Appropriate lab/x-ray (list)			
9	Clinical Guidelines : absence of non-approved abbreviations			

Comments

Signature of Reviewer _____

Anesthesia Peer Review

		YES	NO	N/A
1	Pre-op anesthesia note present and adequate. REEVALUATION OF PATIENT STATUS UPON INDUCTION OF ANESTHESIA.			
2	Choice of anesthesia appropriate.			
3	Absence of Adverse Drug Reactions			
4	Vital Signs Complete			
5	Patient Satus recorded on transfer to PACU			
6	Anesthesia orders signed			

Comments

Signature of Reviewer _____

Elmhurst Foot & Ankle Surgery Center

MEDICAL RECORD/PEER REVIEW WORKSHEET

Year:

QUARTER: 1ST
MONTH: JANUARY

Charts Reviewed:
Total Cases:

PHYSICIAN PEER REVIEW

YES	NO	N/A
0%	0%	0%
0%	0%	0%
0%	0%	0%
0%	0%	0%
0%	0%	0%
0%	0%	0%
0%	0%	0%
0%	0%	0%
0%	0%	0%
0%	0%	0%

		YES	NO	N/A
1	History and physical present and within 30 day timeline.			
2	Operative note present on chart and sufficient. (AT END OF PROCEDURE PRIOR TO SURGEON LEAVING PREMISES).			
3	Surgeon note (operative report) sufficient to indicate surgery.			
4	PATHOLOGY: Specimen removal indicated.			
5	COMPLICATIONS: Management appropriate.			
6	Discharge note/orders present and sufficient.			
7	UTILIZATION REVIEW: Appropriate setting for this surgery.			
8	UTILIZATION REVIEW: Appropriate lab/x-ray (list)			
9	Prescribed medications appropriate for __use, dose, frequency, and duration.			
10	Clinical Guidelines : absence of non-approved abbreviations			

Comments and/or Recommendations:

ANESTHESIA PEER REVIEW

YES	NO	N/A
0%	0%	0%
0%	0%	0%
0%	0%	0%
0%	0%	0%
0%	0%	0%
0%	0%	0%

		YES	NO	N/A
1	Pre-op anesthesia note present and adequate. RE-EVALUATION OF PATIENT STATUS UPON INDUCTION OF ANESTHESIA.			
2	Choice of anesthesia appropriate.			
3	Absence of Adverse Drug Reactions.			
4	Vital signs complete.			
5	Patient Status recorded on transfer to PACU.			
6	Anesthesia orders signed.			

Comments and/or Recommendations:

ATTACHMENT 25k

CLINICAL SERVICE AREAS OTHER THAN CATEGORIES OF SERVICE

A single Stage 1 and two Stage 2 postsurgical recovery stations are the only clinical services, other than surgery, provided in the ASTC. Due to the nature of the proposed project, no changes to those areas are anticipated.

After paginating the entire completed application indicate, in the chart below, the page numbers for the included attachments:

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